Dragon Boat Health Care Limited - Abbey Heights

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Dragon Boat Health Care Limited
Premises audited:	Abbey Heights
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 November 2019 End date: 28 November 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: 22

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

Dragon Boat Health Care Limited - Abbey Heights provides care for up to 24 residents requiring rest home level care.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, families, a general practitioner, managers and staff. An interpreter was used for all resident and family interviews, as all residents spoke Cantonese or Mandarin. Some staff were also interviewed with the assistance of an interpreter as they had limited ability to communicate in English or had English as their second language .

There were no areas identified as requiring improvement at this audit.

Residents and family members interviewed were satisfied with the manager, staff and the services they provide.

Consumer rights

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

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

Open communication between staff, residents and families is promoted and was confirmed to be effective. All staff speak Chinese and provide residents and families with the information they need to make informed choices and to give consent.

There were no residents that identified as Maori at the time of the audit. This service as a particular focus on providing aged residential care for Chinese residents. Information is readily available to guide staff if a resident was admitted who identified as Maori. There was no evidence of abuse, neglect or discrimination.

The service has links with a range of specialist health providers to support best practice and to meet residents' needs.

Complaints are rarely received, and are acknowledged, investigated and responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The organisation's philosophy, mission and vision statement are identified in the business and strategic plan. The manager (who has been the rest home owner since April 2019), and the other members of the management team work together to ensure service planning covers business strategies for all aspects of service. The services offered meet residents' needs, legislative requirements and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, hazard management, resident satisfaction surveys,

and enabler and infection control data collection. Quality and risk management activities and results are shared among managers, staff, residents and families, as appropriate. Corrective action planning is well documented.

New staff have an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met.

The service has a documented rationale for staffing which is implemented.

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

Continuum of service delivery

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

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

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

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

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

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

Safe and appropriate environment

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

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes which were understood and implemented by staff. This included six monthly fire drills.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no significant changes to the facility since the previous audit except for some renovation and refurbishment.

The facilities meet residents' needs and provided furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. There is adequate toilet, bathing and hand washing facilities.

The lounge and dining areas meet residents' relaxation, activity and dining needs. There are external areas where residents and family members can go to for recreation. The outdoor areas provide furnishings and shade for residents' use.

The facility is kept at a suitable temperature. Opening doors and windows creates an air floor to keep the facility cool when required.

Appropriate security is in place, and security cameras were in use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The service has a commitment to not using restraint. The restraint minimisation and safe practice policy and definitions complied with the standard. There were no restraints or enablers in use during the audit. There is a gate to the property which is kept closed at all times. The pin number to open the gates is noted on the gate and is visible from the inside and outside of the gate. All the residents and family members interviewed advised they can freely enter and exit the property and the gate does not restrict their access or freedom of movement.

Staff are provided with ongoing education on restraint minimisation and use of enablers.

Infection prevention and control

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

The infection prevention and control programme is appropriate for the size and nature of this rest home service. The programme is led by a registered nurse and aims to prevent and manage infections. The programme is reviewed annually and aims are set. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Abbey Heights has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed (with an interpreter arranged for the audit from ADHB) understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all new staff employed and in ongoing education and training and this was verified in the training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The two RNs and care staff interviewed understood the principles of informed consent. Informed consent policies provided relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Staff were seen to gain consent for day to day care. Separate consent forms were utilised for the influenza vaccination offered annually.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process residents are given a copy of the Code translated into Chinese. The brochure also includes information on the Nationwide Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available at the facility. Family members and residents interviewed were fully aware of the advocacy service and how to access this and their right to have support persons. An aged concern representative has provided staff training in relation to advocacy services and the Code.
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 are assisted to maximise their potential and to maintain links with family and the community by attending a variety of organised outings, visits, shopping, church services, activities and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members all interviewed individually with the aid of the interpreter stated they felt welcomed when they visited the facility and comfortable in their dealings with the manager and/or the staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Abbey Heights implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process and noted they had no complaints. Feedback forms are present at the main entrance and included an area for the recording of complaints, feedback and compliments. The forms contained information written in both English and Chinese. A complaints register is maintained and associated records were verified. Complaints were investigated and responded to in a timely manner. Three complaints of a minor nature have been received in 2019. There have been no complaints received from the District Health Board (DHB), Ministry of Health or Health (MOH) and Health and Disability Commissioner (HDC) since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff including the registered nurses who discuss the Code with residents on admission. The Code is displayed in poster form in English/Maori both upstairs and downstairs in the dining/lounge areas together with information on advocacy services and how to make a complaint. In addition to this, the Code is documented in Chinese and is accessible for the residents to read. Details of resident's legal representatives were noted on the individual resident's records reviewed.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed at interview that they received services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room with their spouse, with consent. Two married couples were interviewed with the interpreter and were very pleased with the care and management provided and that their families could visit anytime. The rooms allocated for married couples are spacious and privacy is maintained by staff. Independence is encouraged and most residents are mobile and enjoy outings in the community of their choosing with family and friends, as was during the audit. Care plans included documentation related to the residents' abilities and strategies to maximise independence. Physical exercise to music and instruction are completed every morning with excellent participation of residents.
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 two registered nurses (RNs) interviewed spoke fluent English and an interpreter was not required for interview. The RNs understood what would be required if any residents who identified as Maori were admitted to this facility and policies and procedures are available to guide staff. Tikanga best practice guidelines are accessible. The principles of the Treaty of Waitangi are understood, as is the importance of whanau. There were no Maori residents in the facility at the time of audit; all residents identify as Chinese.
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 resident verified through the interpreter that they were consulted on their individual culture, values and beliefs and the staff respected these. Residents' preferences, required interventions and special needs were included in the care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe at this facility. The induction process for staff includes education on professional boundaries, expected behaviours and the Code of Conduct which is in the individual employment agreement reviewed. The two RNs have completed relevant Code of Conduct training for their annual nursing practising certificates. Staff are guided by policies and procedures and

other exploitation.		demonstrated understanding of the process they would follow should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through input from the WDHB gerontology nurse practitioner as part of the WDHB residential aged care integration programme. Input is sought from relevant services as needed for specialist input to benefit the residents. The general practitioner contacted was not available for interview. Staff reported they receive management support for external education and can access their own professional networks to support contemporary good practice. An holistic approach to service delivery is encouraged and the wellbeing of the residents was evident through observation and during interviews with the use of the interpreter. One registered nurse has decreased her hours of employment to attend university education for the coming year. The newly employed RN will be working full time. The two RNs have introduced a person-centred care plan which includes all criterion of the standards and best practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and families were interviewed with an interpreter assisting the interview process. Family members interviewed by telephone and in person stated they were kept well informed about any changes to their relative's health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the residents' records reviewed. Staff and the manager understood the principles of open disclosure which was supported by policies and procedures that meet the requirements of the Code. The manager and staff employed are all Chinese speaking and rarely require an interpreter service but are aware that they can access the DHB services if needed. Family members are available to assist staff if needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Abbey Heights has a documented mission statement, philosophy and values that is focused around the provision of quality care where residents' independence is encouraged, and individual needs identified and met in order to enhance each resident's quality of life. The philosophy is to 'treat others as you would want to be treated'. The manager (who is also the owner) is readily available to residents and family as verified by residents and families interviewed. The manager, the registered nurses (RN's) and the caregiver team leader monitors the progress in achieving goals via day to day activities, resident / family feedback and

		monitoring of the results of quality and risk activities. The day to day operations and ensuring the wellbeing of residents is the responsibility of the manager. The manager worked for the previous owners of Abbey Heights and their other aged care facilities for over 10 years as the accountant. The manager became responsible for the services provided after the purchase of Abbey Heights which took effect on 2 April 2019. The previous owners remain available and provide the manager with ongoing support with formal meetings occurring fortnightly or sooner as required. The manager leases the facility (land and buildings) which remain owned by the previous owners of Abbey Heights. The manager is aware of the aged related residential care (ARRC) contract requirements, current legislation and care planning requirements. The manager participates in relevant ongoing education as required to meet the provider's contract with Waitemata District Health Board (WDHB). Since the manager became responsible for services, there has been some refurbishment of the facility. This included painting walls in the corridors and communal areas. This aligns with the facility's goals. Two registered nurses support the manager. One was employed in October 2019 and one was employed in February 2019. The two RN's share the responsibilities for oversight of residents' care needs and the clinical services. An RN is rostered on duty Monday to Friday between 9 am and 5 pm and on Saturday between 8 am and 2 pm. One RN has current interRAI competency. Either the manager or the new RN are on site overnight for the 'sleep over shift' and are available to provide assistance to the caregiver on duty if required. One RN is on call when not on site. Both RN's have a current annual practising certificate. The manager, both RNs, and some caregivers can communicate with the residents in their own language and can communicate effectively in English. The cleaner, cook and kitchen assistant were interviewed with the assistance of a Mandarin and Cantonese speaking interpreter from Auckland DHB. The service has a contract with WDHB for the provision of aged related rest home level care. All residents are reported to have been assessed as requiring rest home level care. There are no boarders.
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	FA	The previous owner of Abbey Heights is responsible for services in the manager's absence. There is a signed agreement between both parties to this effect. The previous owner was on site on the first morning of audit and confirmed being available for support and covering the manager role as and when required, and was aware of the residents' care needs and knows the residents and their family members.

services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Abbey Heights has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, the health and safety programme, hazard management, infection control data collection and management, restraint minimisation and complaints / compliments management. Regular internal audits are conducted and the results of seven audits sampled demonstrated a high level of compliance with organisation policy. A resident satisfaction survey was conducted in November 2019. Feedback was received from 14 residents and was positive about the services provided. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions were developed and implemented. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. In addition, quarterly service review meetings are held. Templates are used to discuss individual resident's needs, incident/accidents, audits, complaint and other quality and risk data along. An annual review is undertaken on the medicine's management programme, infection prevention and control programme, recreation programme and the restraint minimisation programme. Opportunities for improvement are discussed, along with identifying areas of compliance with Abbey Height's expectations/policies. The manager holds meetings every four to six weeks with residents to obtain residents' feedback on services, food, and activities as well as to obtain information for future planning. The minutes of three recent meetings were sighted. Policies and procedures were readily available for staff. Policies have been developed by an external consultant (dated January 2019) and localised to reflect the needs of Abbey Heights. These have been updated since the manager purchased the rest home to include the roles / personnel now responsible for various aspects of management and service delivery. Two paper copy of policies were available for staff. One copy is held in the manager's office and the other copy is held at the nursing station. The manager is responsible for document control processes. Staff, residents and family members interviewed expressed a high level of satisfaction about the services provided at Abbey Heights. Actual and potential risks are identified in the quality and risk plan. These were reviewed in 2019. Mitigation strategies have been documented. The manager could detail organisation risks and how these were being addressed. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. Maintenance issues are reported in real time and in the records sighted all reported events have been promptly addressed.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Policy and procedure detailed the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme. Applicable events are being reported in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by residents and all family members interviewed. A review of reported events including falls, bruising, a medicine error, and a skin tear demonstrated that incident reports were completed, incidents were investigated and responded to in a timely manner. Staff communicated incidents and events to oncoming staff via the shift handover. A summary of events was discussed with staff at the staff meetings as detailed in meeting minutes sighted and reviewed at the quarterly service review meetings. Staff also reported all cases via the incident system when residents are transferred to the DHB for care to enable review and follow-up of processes. This documentation was also reviewed during audit. The manager is aware of the events that are required to reported to external agencies including the DHB and HealthCERT and the process. The manager advised there have been no events that have required external notification since 2 April 2019 when he became responsible for services.
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	Copies of the annual practising certificates (APCs) were sighted for the three general practitioners (GPs) (including those that provide cover in the GP's absence), the four pharmacists, dietitian, podiatrist, and two registered nurses (RNs). Recruitment processes included completing an application form, conducting interviews and reference checks. Police vetting is occurring for new staff at employment. Staff have a job description on file. The job description / employment contract and confidentiality documents included a statement advising staff of privacy / confidentiality requirements. A progress review is undertaken a week and then three months after commencing, with annual performance appraisals occurring thereafter. The reviews were documented, along with the annual performance appraisals which were current in the applicable staff files sampled. New employees are required to complete an orientation programme relevant to their role. A workbook is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. A staff education programme was in place with in-service education provided monthly. The topics are scheduled over a two-year period and align with the Abbey Height's contract with WDHB. Education provided in 2019 year to date, included fire safety, abuse and neglect, the aging process, restraint minimisation, delirium, death and dying, oral health care, diabetes, health and safety, pressure injury prevention and management and chemical safety. Education has been provided by an RN, the manager,

		fire safety consultant, or gerontology nurse practitioner. Staff can also attend relevant external education provide for the 'ARRC' sector with regular education topics scheduled and provided by DHB staff. Records of education were maintained, and copies of some education certificates were present in the staff files reviewed. There are processes in place to ensure staff ongoing competency for medicines management. One RN has completed interRAI competency in 2019. There were no caregivers currently working to complete an industry approved qualification. Some of the caregivers have worked as registered nurses overseas.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Waitemata District Health Board (WDHB). The current roster was reviewed as well as past rosters from 4 October 2019 onwards. Replacement staff were noted on the roster when the rostered staff member was unable to complete the shift for any reason. The manager is on site weekdays and some weekend days and assist with activities (refer to 1.3.7), maintenance, accounts management and other tasks as required. One caregiver is rostered on every morning, afternoon and night shift. The manager advised that additional staff hours would be allocated to meet the care needs of the residents if required. One RN is on site weekdays from 9 am to 5 pm and Saturday 8 am to 2 pm. The two RN's share these shifts. The manager and an RN are on call when not on site. This was verified by interview with the RN's, manager and the caregivers. One of the RNs or the manager are on site overnight every night in a' sleep over' role. This enables the caregiver on duty to have prompt assistance if and when required. A cleaner is rostered on duty six hours a day, each day. The cleaner is also responsible for laundry services. A cook is rostered on duty from 7 am to 12 pm and 2 pm to 5 pm, seven days a week. Two staff share this responsibility. A kitchen hand assists between 7 am to 12.30 pm and 4 pm to 7 pm. The manager assists with taking residents to health appointments off site in the event a family member is unable to attend with the resident. A staff member with a current first aid certificate is on duty at all times, including accompanying the residents on outings. Residents and the family members interviewed confirmed their personal and other care needs are being well met. The manager advised there were no staff vacancies. Volunteers are not involved in providing services.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with the general practitioner (GP), nursing and allied health professionals' records together in the one record. This includes the interRAI assessment and outcome information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archive records are held securely on site and are readily retrievable. Residents' records are held for the required period of time before being destroyed. No personal or private resident information was on public display during the audit. The current records were stored at the nurses' station and locked away at all times when not in use.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC or GP for residents when accessing the service for respite care. All current residents are receiving long term services. Family members interviewed in person and by telephone (with the DHB interpreter assistance) stated that they were satisfied with the admission process and the information provided to them. Records reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Services charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner with an escort as appropriate. The service uses the DHB 'yellow envelope' system to facilitate the transfer of residents to and from acute services. There is open communication between services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. A family member interviewed when their relative was transferred to the DHB spoke highly of the transfer and commented that they were kept well informed throughout the process. They were able to be at the DHB to assist with translation as their family member spoke no English.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medicine management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A system for medicine management using an electronic system was observed on the days of the audit. The staff observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Only one resident was on a controlled medication and this was stored safely and appropriately in a locked cupboard. The medication was checked by two staff for accuracy when administering. The controlled drug register was maintained and provided evidence of weekly checks and accurate entries. The small fridge used for medicines was checked daily and the temperature was recorded. The locked medicine trolley was stored in the main office when not in use. Good prescribing practices were noted on the electronic system and evidenced three monthly reviews occurred. Any allergies and sensitivities were recorded. All requirements for pro re nata (PRN) medicines were met. There were no standing orders and no residents who were self-administering medications. A process is in place should this arise. There is an implemented process for any medication errors to be reported and analysed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by a cook and kitchen hand and was in line with recognised guidelines for older people. The menu plans are documented in Chinese and the daily menu is displayed on the whiteboard both upstairs and downstairs near the dining rooms. The menu has been reviewed by a dietitian in the last two years. The cook and kitchen hand were interviewed with the interpreter being present. The cook caters for the residents who are from the north and south of China. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The manager orders the foods required and purchases fresh fruit and vegetables three times a week. The service operates with an approved food safety plan and registration issued by the local council - expiry 14 January 2020. Food temperatures were monitored appropriately and recorded as part of the plan. The kitchen staff have completed food safety courses. A nutritional assessment is undertaken for each resident on admission by the RN and the dietary profile is developed. The personal food preferences or any special diets or modified textures required are made

		known to the cook and accommodated on a daily basis in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meetings minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring any assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family is supported to find an appropriate care alternative. If the needs of the resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and family. There is also a clause in the access service agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information was documented using validated recognised assessment tools, such as a pain assessment, mini nutritional assessment, water-low pressure injury, falls assessments and interRAI assessments. These tools are used to identify any deficits and to inform the long-term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the one interRAI competent RN assessor on site. Residents and families interviewed confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other clinically relevant information. The needs identified by the interRAI assessments were reflected in the care plans reviewed. The care plans evidence service integration with progress notes, daily care logs, and activities notes. Medical and allied health professionals' notations were clearly documented, informative and relevant. Any change in care required was clearly documented and verbally passed on to relevant staff. Residents and families interviewed reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	Documentation, observations and interviews verified the care provided to residents was consistent with meeting their needs, goals and the plan of care. The practical policy and work instruction manual was available to guide care staff. This also included an oral health policy and a form which is completed on

and appropriate services in order to meet their assessed needs and desired outcomes.		admission. The attention to meeting the individualised needs was evident in all areas of service provision. The RNs and care staff confirmed at interview that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the rest home level care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	On admission, the RN completes a 'resident wishing list', and from this the resident lifestyle planning is completed for each individual resident. Attendance at activities is recorded and updated monthly. There is a facility van which seats seven residents available and outings are arranged each day. The programme provided suites the nature of the service and the individuals who are all currently mobile. The manager and a caregiver are the activities coordinators. Activities provided reflected residents' goals, ordinary patterns of life and included normal community activities, with individual, group and regular events offered. Residents' meetings are held regularly for residents and family and the activities are evaluated. Residents and families interviewed stated that the programme meets the needs of the residents and family can attend if they wish to.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress records. If any change is noted it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are used for any problems/issues that may arise and these are consistently evaluated as clinically indicated, for example, skin tears, eye infections or urinary tract infections. When necessary and for unresolved problems, long term care plans were added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes. One family member interviewed by telephone with the input of an interpreter, acknowledged the staff for observing a change in their relative and transferring the resident to the DHB in a timely manner which resulted in a successful outcome for the resident.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or	FA	Residents are supported to access or seek referral to other health and disability service providers. Although the service has a resident doctor, residents may choose to use another medical practitioner. Two doctors cover the service presently both from the same medical practice. If the need for other non-urgent services are indicated or requested the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the residents' records reviewed including dental, radiology, gerontology nurse

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		practitioner and other services. The resident and the family/whanau are kept well informed of the referral process as verified by documentation reviewed and in interviews. Any urgent/acute referrals are attended to immediately and transportation is arranged if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Chemicals are stored securely. An external company is contracted to supply all chemicals and cleaning products. Safe chemical handling training and education is undertaken as part of the staff in-service education programme, most recently on 20 November 2019. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment as confirmed by staff during interview and observed use was noted during the audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 08 November 2020) was publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The manager is responsible for ensuring maintenance requests are undertaken. This includes using contractors where required. Calibration of bio medical equipment (expiry 30 October 2020) has occurred as confirmed in documentation reviewed, interviews with the manager and observation of the environment. The temperature of hot water is tested monthly and was within the required temperature range. The environment was hazard free, residents advised they felt safe and their independence was promoted. External areas are safely maintained and are appropriate to the resident group and setting. There is a door for access to the outside from every resident's bedroom. Residents and families interviewed had no concerns related to the internal or external environment. Some refurbishment / renovations have been undertaken since April 2019. This included painting the internal walls in the corridors and communal residents' areas. There is an ongoing maintenance plan in place for 2019 and 2020.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing	FA	There are adequate numbers of accessible bathroom and toilet facilities. This includes three bedrooms with full ensuite facilities, and thirteen rooms on the lower level with an ensuite toilet and hand basin. Appropriately secured and approved handrails are provided in the toilet/shower areas, and on both sides of the internal stairs, and other equipment/accessories are available to promote residents' independence. Privacy locks and appropriate signage is on bathroom facility doors. Waterless hand hygiene products

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		are readily available. There is a designated toilet for staff and visitors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. This was confirmed during staff interviews. There are four bedrooms which are shared rooms, but the manager confirmed they are only used for couples. At the time of audit, two double rooms were occupied by married couples, and all other bedrooms were single occupancy. Where rooms are shared, approval has been sought, and the manager advised the residents satisfaction with this is regularly monitored. Rooms were personalised with furnishings, photos and other personal items displayed. Residents and family members confirmed their satisfaction with their bedrooms. Mobility aids are kept in residents' bedrooms. One resident has two 'bed loops' attached to their bed. The family member advised this was because the resident changed the end of the bed they placed their head and this enabled the resident to safely mobilise independently regardless of this.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There are adequate dining and lounge areas, which cater for all residents' dining and relaxation needs. There is also a room for activities. Residents can access areas for privacy, if required. The furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in two dedicated laundry areas. There is also one washing machine in the downstairs laundry which belongs to a resident and is only used for this resident's laundry. One of the two cleaners who is also responsible for laundry services was interviewed, and demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents' clothes are washed in individual cycles. There is no mixing of residents' clothing during washing. Residents interviewed reported the laundry is managed well and their clothes are washed, dried and returned in a timely manner. The cleaner confirmed she had received appropriate training including chemical safety and their required duties. The facility looked and smelled clean. Chemicals were stored in locked cupboards and were in

		appropriately labelled containers. Cleaning and laundry processes are monitored through internal audits, resident satisfaction surveys and the manager's regular observations. Some residents choose to hand wash some of their clothing and have a portable clothes airing rack on the deck outside their bedroom, as part of remaining independent. Staff advised they assist the residents as appropriate and needed.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The fire evacuation plan was approved by the New Zealand Fire Service on the 18 November 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 31 May 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. There is at least one staff member on duty at all times with a current first aid certificate. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phone, personal protective equipment, clinical consumables, spare blankets, and gas BBQ's were sighted and meet the requirements for up to 24 residents. Bottled water storage is located in a designated area and changed every three months with records retained of this. Call bells alert staff to residents requiring assistance and alert audibly to two centralised panels as well as via an illuminated light outside the applicable door. Residents and families reported staff responded promptly to call bells. There are ten security cameras in use that monitor internal communal resident areas and the front door. The images are displayed on a screen in the manager's office. The manager advised being able to access security images remotely. The images are stored for four weeks before being recorded over. The manager advised the images are reviewed if necessary to evaluate specific events, for example, the circumstances related to a resident's fall. There is signage on the outside of the facility that alerts residents, family members and other visitors that security cameras are in use. Family members interviewed confirmed being informed about the security cameras when their family member was admitted and having no concerns about their use. Staff advise they lock the door and close the windows at designated times. The caregiver on night duty also undertakes a security check to ensure all doors and windows are appropriately secured and all residents are accounted for. The caregiver stated overnight all residents are visually checked at least two hourly or sooner where required.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and all bedrooms have ranch slider doors that open onto outside deck areas. Heating is provided by thermostat controlled wall mounted electric heaters in residents' rooms and

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		in the communal areas. Areas were appropriately warm and well ventilated throughout the audit and residents and families interviewed on this topic confirmed the facilities were maintained at a comfortable temperature regardless of the season and weather. Smoking is only allowed in designated external areas. The RNs support consenting residents to access nicotine replacement support where applicable (refer to 1.3.3).
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a manual with all relevant policies and procedures to support staff. The manual and plan are reviewed annually. The programme had five aims set for 2019. One of the two RNs is responsible for the programme implementation and is the designated infection control coordinator (ICC). The role and responsibilities are part of the RN job description. Infection control matters, including surveillance, are reported to the manager monthly and tabled at the staff/quality meetings. Signage was observed to remind anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The RN has appropriate skills, knowledge and qualifications for this role and has been in this role for one year. Staff training has been provided. Additional support and information is available and accessible from the WDHB infection control team, the community laboratory and the GP or nurse practitioner as required. The ICC has access to residents' records and a printout of all infections from the laboratory on a monthly basis is received. This ensures timely treatment and resolution of any infections. The infection rate was very low at the facility. The ICC confirmed the availability of resources to support the programme and any outbreaks of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as use of hand sanitisers, good hand washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education was provided to all staff by the gerontology nurse practitioner from WDHB on the 12 February 2019. The ICC RN attended a one-day education session at the DHB on recognising infection in older adults living in residential care on the 6 June 2019. The RNs also provide infection control education with care staff. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. There have been no outbreaks of infection. Education with residents is usually on a one to one basis and has involved handwashing technique.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for an aged care residential service and included infections of the urinary tract, soft tissue, fungal, eye, gastroenteritis, upper and lower respiratory tract and skin infections. The ICC reviews all reported infections, and these were documented. Any new infections and any required management plan are discussed at the handover between the shifts to ensure early intervention occurs. Monthly surveillance data is collated by the RN and manager and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via the staff meetings and at staff handover. Graphs were produced that identified any trends for the current year and were compared with the previous year.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures identify that the facility is restraint free. There is a coded number gate on the external car park entrance. All residents and family members confirmed they can come and go as they wish and that they have no problems with opening this gate. The code to open the gate is displayed on both sides of the gate. This is in place owing to members of the public using the facility car park if the gate is kept open. All policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers should they be

		implemented. The manager is the restraint coordinator, supported by the two RN's. The restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, no residents were using restraints or enablers. Enablers were described in policy as the least restrictive and used voluntarily at a resident's request. Restraint would only be used as a last resort when all alternatives have been explored. The restraint coordinator understood the required approval and review process. Staff education related to restraint is undertaken annually as identified in the staff education sighted. This last occurred in February 2019.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.