Benhaven Care Limited - Camellia Resthome

Introduction

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

The audit has been conducted by HealthShare 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:	Benhaven Care Limited
Premises audited:	Camellia Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 December 2019 End date: 17 December 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: 30

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

General overview of the audit

Benhaven Care Limited (the prospective provider) has a sale and purchase agreement with Level 52 Limited, to buy Camellia Rest Home in Te Awamutu. The anticipated takeover date is 17 January 2020, which is dependent on obtaining approval from the Ministry of Health (MOH).

This provisional audit was undertaken to establish the prospective provider's preparedness to deliver residential aged care services and the current owner's level of conformity with the Health and Disability Services Standards and their agreements with the district health board.

The prospective provider owns and has operated an aged care facility (Benhaven Care) in Upper Hutt, Wellington for six years. Interview with the two directors of Benhaven Care provided evidence of their knowledge and understanding of the aged care sector and their preparedness to own and operate an additional facility. Specific evidence is described in the body of this report.

The audit process included a pre audit review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the current owner, staff including a contracted quality coordinator and a general practitioner (GP).

All the interviewees spoke positively about the care provided.

There have been no significant changes to the services provided or the facility since the previous certification audit in August 2018. The current owner stated there are no changes planned which may affect the ability of the prospective provider to meet the requirements of these standards.

The MOH requested that the audit process comment specifically on criteria related to a complaint investigation by the Office of the Health and Disability Commissioner in 2018. These are described in standards 1.2.7, 1.3.3, 1.3.4, 1.3.5 and 1.3.6 of this report.

There were six areas identified as requiring improvement during this audit. These relate to limited evidence of corrective actions being implemented where required, reporting and documenting of adverse events, service delivery plans not fully reflecting resident's needs, absence of GP records, evaluation of care plans, and aspects of the medication system.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Camellia Rest Home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Care and support occurs in ways which recognise the residents' culture, values and beliefs. Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with

residents in a respectful manner. Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles.

Open communication between staff, residents and families is promoted, and confirmed to be effective. Adequately documented processes are in place for informed consent. Advocacy information is available for residents and family/whanau. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints management process is clearly described in policy. Residents and relatives are advised on entry to the home about the processes for raising concerns or complaints and are given written information about their right to complain and where to access independent support and advocacy if required. The service is managing complaints fairly and openly.

Organisational management

The prospective provider has a documented business transition plan which was reviewed and discussed during interview. The plan outlines objectives for a smooth transition and shows that the prospective provider has completed due diligence in considering the strengths, weaknesses, opportunities and threats of acquiring the business. The prospective purchaser demonstrated knowledge and understanding about all the requirements for delivering residential rest home care to older people under NZ legislation, these standards and funding agreements. They plan to continue using the quality, risk and human resource systems already in place. The current business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation which are reviewed for progress annually by the owner/operator. A non-clinical facility manager and an RN is on site five days a week with an on call RN always available to oversee clinical care of residents.

There is an established quality and risk management system which includes collection and analysis of quality improvement data. Staff are involved in monitoring service delivery and feedback is sought from residents and families. There is a system for reporting and documenting adverse events. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff adheres to good employment practices. A systematic approach to identify and deliver ongoing staff training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using integrated hard copy files.

Continuum of service delivery

Camellia Rest Home works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multi-disciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

The nursing team at Camellia Rest Home is responsible for the development of care plans. Care plans and assessments are individualised, based on a range of information. Acute care plans are developed to manage wounds and infections. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two part time activities coordinators and provides residents with a variety of individual and group activities and maintains their links with the community. Residents and family/whanau interviewed expressed satisfaction with the activities provided by the activity coordinators. A facility car is available for outings.

Medicines are managed using a manual system. Medication is administered by staff with current medication competencies.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents who require special or modified meals are reliably catered for and verified overall satisfaction with meals.

Safe and appropriate environment

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this. Chemicals are safely stored.

The building is in good order, has a current building warrant of fitness and meets the needs of residents. Electrical equipment and equipment is tested as required. External areas are accessible, safe and provide shade and seating for residents. All areas of the home are well maintained and cleaned to a high standard. Laundry services are effective. This is managed by a designated laundry person Monday to Friday and care staff on the weekends.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained. Communal and individual spaces are maintained at a comfortable temperature

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints and six residents using enablers at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection prevention and control programme is led by an appropriately trained infection control coordinator and aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Waikato District Health Board.

The programme is reviewed annually.

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, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	40	0	2	3	0	0
Criteria	0	87	0	2	4	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	Camellia Rest Home (Camellia) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. The Code is included in staff orientation and in the staff training education programmes, as was verified in training records. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents.
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	Policies and procedures on consent support residents' right to make informed decisions. Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs,

		outings, invasive procedures and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent, are defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff acknowledged the residents' right to make choices based on information presented to them and were observed to gain consent for day to day care on an ongoing basis. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service are accessible in the front entrance foyer. Staff training on the right to advocacy/support is provided annually and staff demonstrated understanding of how residents can access advocacy/support persons. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
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 of Camellia are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.

Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints process and related information meets the requirements of Right 10 of the Code. Information about how to raise a complaint is available and explained to residents and families on admission. Residents and families said they understood their right to complain and that they would not hesitate to do so when needed. The complaints register showed that three complaints have been received since the previous audit. In each case actions were documented and an agreed resolution occurred within a suitable timeframe. The corrective action identified on the 2018 certification audit which required all complaints to be documented is now resolved. The facility manager and current owner take responsibility for complaint management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A complaint investigated by the Office of the Health and Disability Commission in 2018 was found to be partially substantiated. The service provider has made attempts to remedy the corrective actions required .Specific comments about the implementation of the improvements required are made in 1.2.7, 1.3.3, 1.3.4, 1.3.5, 1.3.6.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information about the Code, advocacy services and the complaints process are provided on admission and displayed at the entrance to the facility. Residents and family interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. Camellia's information pack was sighted and outlines the services offered. An interview with the prospective provider verified knowledge and an understanding of the obligation to adhere to the Code.
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 family members of residents confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. The privacy and dignity policy explains how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents'

		related information. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room. Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.
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	There were no residents in Camellia at the time of audit who identified as Māori, however interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The Maori perspective on health is documented and includes Maori models of health and barriers to access. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Cultural needs are included in the care plans (if identified). Several staff members interviewed identify as Maori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and	FA	Cultural needs are assessed on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner. Residents verified that they were

respect their ethnic, cultural, spiritual values, and beliefs.		consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and from interviews, staff demonstrated an understanding of cultural safety in relation to care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Policies sighted evidence processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. The staff code of conduct and professional behaviour is part of their individual employment contract and orientation process. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are systems in place to ensure staff receive a wide range of opportunities which promote good practice within the facility for example, wound care specialists, services for older people, psychogeriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.

		Staff reported they were satisfied with the relevance of the education provided and receive management support for external education and access to their own professional networks, such as on-line forums, to support contemporary good practice. Other examples of good practice observed during the audit included an environment where residents expressed a high level of satisfaction in the services provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Documentation regarding open disclosure following incidents/accidents was evident and staff understood the principles of open disclosure. The service has access to interpreting services for the residents if required. Policies and procedures are in place if the interpreter services are needed to be accessed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Camellia Rest Home has been owned and operated by a private owner for the past 14 years. Maximum occupancy is for 30 residents. On the days of audit there were 30 residents receiving rest home level care services under the age residential care contract (ARCC) with the DHB. The service also has agreements with the DHB to deliver a day programme for older people and short term/respite care. All residents had signed admission agreements. The current facility manager has been in the post for 18 months but was not available on the days of audit. This person is not a health care professional but has skills and work experience in administration and financial accounting. Their authority, accountability and responsibility for the provision of services is described in the position description attached to their employment agreement. The facility manager has been supported and mentored by an RN quality consultant who is on

		site for ten hours per week or as required. The new facility manager has completed industry specific training and attends sector network meetings to obtain and maintain the skills and knowledge required. There are two registered nurses employed who oversee the day to day clinical care of residents. The prospective provider produced a documented business/transitional plan which describes their objectives for a smooth change of ownership and their governance and management structure. The transition plan includes mission statement, values and service philosophy and the intention to create a one year business plan specific to Camellia House. The two directors have owned and operated a 21 bed aged care residential facility (Benhaven Care) in Upper Hutt, Wellington since July 2013. That service has agreements with Hutt Valley DHB to provide residential services for aged related care, and a contract with MOH for people under 65 years of age with an intellectual or physical disability. Their agreements include respite/short stay, and day programme services. This service was audited in April 2019 and obtained a four year certification period. Interviews with both directors confirmed their knowledge and understanding of their responsibilities and sector requirements. One of the directors has a NZ Masters of Business Administration and was previously a lecturer in executive and business management, and employment law. This person has a masters of education from China. Their stated and documented intention is to maintain the current management structure, which is a part time employed facility manager (five hours a day for five days) or 25 hours per week, and registered nurses employed for a total of 72 hours per fortnight. The current owner and prospective purchaser have a sale and purchase agreement which states expected takeover on 17 January 2020.
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	FA	The business transitional plan states that the prospective purchaser will offer the Camellia House staff an employment agreement under Benhaven Care Limited according to their existing rosters. The prospective purchaser plans to be onsite Monday to Friday every other

provision of timely, appropriate, and safe services to consumers.		week and continue using all the existing systems, such as the quality and risk system, and adhere to the same timeframes for staff and management meetings. The transition plan discusses regular liaison with key stakeholders such as the local general practitioners, portfolio manager at Waikato DHB, other service providers, residents and their families. There are no stated plans to change the buildings, service scope or the ways in which service delivery currently occurs. Currently the owner/operator is on site for at least one day a week. Absence of the facility manager is covered by an RN/quality consultant who used to own and operate a local residential aged care service. This person has been providing support and assistance to Camellia House for at least two years under contract and as required.
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.	PA Low	Currently the quality and risk management plan is aligned to the annual business plan and clearly describes the systems for service monitoring, review and quality improvement. Service goals are documented in a business plan which are monitored for progress by the owner/operator. A pre audit review of the sector standardised policies and procedures showed these are individualised and updated as required by the owner of the quality system and the contracted RN/consultant. The prospective purchaser plans to continue using the existing service policies and quality and risk system in the short to medium term. Review of the documented outcomes from internal audits and incidents reported since the previous recertification audit in august 2018 revealed areas for improvement (refer 1.2.3.8). Although the statistics for incidents and infections are collated, and findings from audits are presented and discussed at staff and management meetings, it was not clear that improvements had been actioned and then checked for effectiveness. The prospective purchaser understands the requirements of the Health and Safety at Work Act 2015 including notifying staff when changes in practice or policies have occurred. The nominated health and safety staff representative has in depth understanding of the role, legislation

		and carries out frequent environmental safety inspections. Minutes of residents' meetings confirmed that residents are consulted about service delivery and are kept informed. Resident and relative satisfaction is formally surveyed annually and the results of these showed high satisfaction. The residents interviewed stated they are kept informed and are consulted about services in ways that they understand. The organisation's annual quality plan, business plan and associated emergency plans describe actual and potential risk to the business, service delivery, staff and/or visitor's health and safety. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk. There is a current hazard register and all risks and health and safety are discussed at staff meetings. This was confirmed by review of meeting minutes and interview with staff and management. The owner/manager oversees quality and risk systems when on site. The prospective purchaser stated they will stay on site every alternate week.
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	The service has known processes for reporting, recording, investigating and reviewing adverse events. The prospective purchaser demonstrated understanding of the requirements for adverse event reporting including making notifications under section 31. A sample of incident/accident records and monthly summary sheets for 2019 showed there was a coordinated approach to the management and review of the documented adverse events. But no incident forms could be located for three recent incidents. Subsequently there was no evidence that the events had been reviewed or corrective actions carried out as per the accident/incident policy. Improvements are required in criteria 1.2.4.3 The facility manager compiles a monthly summary sheet and collates the results into graphs to compare the data month by month. All data is shared with staff at their meetings and the graphs are displayed. Any negative trends result in mitigating strategies being implemented in a timely manner.

		Interviews with staff, the facility manager, quality consultant and owner/operator and the event forms, confirmed that all incidents are reported, recorded and reviewed as soon as possible. Each event is investigated for cause and corrective/ remedial actions are implemented where necessary. The event forms reliably record who has been notified. There have been no events at Camellia House that required notification under section 31 since the previous audit.
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	The prospective provider demonstrated knowledge and understanding about NZ employment legislation. One of the directors has an MBA and taught employment and commercial law in New Zealand previous to purchasing a residential care facility. Review of their transition plan and interview revealed they do not want to change the current configuration of staff at Camellia House and will be maintaining the current systems for human resource management. Staff are recruited and managed in accordance with good employer practices. The owner/operator understands and complies with current employment legislation. The skills and knowledge required for each role is documented in position descriptions and employment agreements. All staff interviewed confirmed they understood their roles, delegated authority and responsibilities. Each of the staff records sampled contained curriculum vitaes (CVs), educational achievements, and evidence of referee and police checks, and current practising certificate for the registered nurses. New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint minimisation, infection prevention and control and emergency situations. There was evidence in the six staff records sampled that performance appraisals are conducted annually. Staff maintain knowledge and skills in emergency management, and competencies in medicine administration (for the staff who administer medicines). In service education is provided monthly on a range of subject areas including infection control, resident rights, manual handling, health and

		safety. The service provider supports all staff to engage in ongoing training and education related to care of older people or the tasks they are employed for. Cooks, cleaners, laundry and all long-term care staff have completed qualifications in care of older people. Two of the 14 care staff have obtained Level 4 of the national certificate, seven have level 3 and two are at level 2. The other three long term employed care staff had previously completed the ACE programme.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Interview with the prospective provider and their transition plan stated no changes with the configuration and numbers of staff currently employed. They intend to maintain the same rosters unless there is a need to change for resident safety. They are aware that a senior carer is due to retire in February 2020 and that recruitment is still underway to replace the long serving cook who retired recently. The current cook is temporarily employed. The reviewed staffing policies adequately describe process for determining stall levels/skill mix and a staff to resident ratio protocol. The sighted staff rosters included appropriate levels of staff and skill mix. Review of previous months and future planned rosters confirmed an appropriate number of staff on site for the needs of the current resident population. There are three care staff on duty each morning and afternoon (one is a short shift) and one care staff member at night. Two activities coordinators, a cook, laundry person and a cleaner are on site for a suitable number of hours Monday to Friday. Kitchen staff are rostered on each weekend but no cleaning or laundry staff, care staff are tasked with laundry duties each Saturday and Sunday. Two registered nurses are employed for a total of 116 hours a fortnight. One is employed for eight hours every Monday and Friday and the other is on site Monday to Thursday one week and Monday to Friday the other week. This provides for at least one RN on the AM shift and rostered on call, 24 hours a day and seven days a week. The residents interviewed said they were satisfied with the availability of staff. Family members said they had no concerns about staffing. All the staff interviewed expressed job satisfaction. Camellia House has a high staff retention rate. Although the care staff interviewed from

		each shift said there were enough suitably skilled and experienced staff on all shifts, they disliked working weekends because laundry tasks made the workload harder. This was discussed with the owner during the audit. The service provider is not currently using bureau staff as most staff are willing to do extra shifts to cover for absences or when workload or resident acuity increases.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All records sighted at Camellia are in hard copy. Residents' records sighted are legible, signed by the writer and integrated. The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and except for GP notes (refer criterion 1.3.5.3), integrated with allied health service providers. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
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 are admitted to Camellia 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. Camellias welcome pack contains all the information about entry to the service. Residents and their family/whanau are provided with written information about the service and the admission process. Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in

		accordance 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. There is a documented process for the management of transfers and discharges. The service uses the Waikato District Health Board's (WDHB) yellow, emergency care referral form to facilitate transfer of residents to and from acute care services. There is open communication between all services. Residents and their families are involved in all exit or discharges to and from the service and there was enough evidence in the residents' records to confirm this. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines have been deemed by the RN as competent to perform the function they manage. A safe system for medicine management using a manual system was not observed on the day of audit. A review of incident forms around medication errors (seven since August 2019), the observed administration of a controlled drug, and the identified incorrect administration of a medication during audit, evidences the process around medication competency requires corrective action. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. The controlled drug register is current and correct. The legislative

		requirement for six monthly checks of controlled drugs was unknown to the RN and had not occurred, this requires attention. Weekly stock takes are conducted, and all medications are stored appropriately. Controlled drugs are stored securely in accordance with requirements. The records of temperatures for the medicine fridge are within the recommended range, no evidence is sighted of temperatures in the medication room being monitored and within the required range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medication chart. There were two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and the facility manager (FM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is no evidence of a comprehensive analysis and corrective actions being implemented following any medication errors (refer criterion 1.2.3.8). Standing orders are not used at Camellia.
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 at Camellia rest home is provided on site by two cooks. The full-time cook has recently left and a recruitment process is in place. A relieving cook is fulfilling the role in the meantime, is qualified and has training in safe food handling. The menu has been reviewed by a dietician in March 2018 and suggestions made at the time have been addressed. Camellia has a food control plan in place which is registered with the Waipa District Council. A verification audit of the food control plan was undertaken July 16-2019. Areas requiring corrective action have been addressed. All aspects of food procurement, production, preparation, storage,

		transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.
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 are supported to find an appropriate care alternative. If the needs of a 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 whānau/family. Examples of this occurring were discussed with the Registered Nurse (RN). There is a clause in the admission 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	The initial assessments of residents admitted to Camellia are completed within the required time frame, while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more

		frequently as residents changing conditions require. The interRAI assessments at Camelia are completed by an external contractor with the input of the onsite RN, as the RNs onsite are not interRAI trained. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. All residents have current interRAI assessments completed. InterRAI assessments are used to inform the care plan. A review of residents who have had recent falls, verifies a post falls assessment was carried out. In the event the resident may have banged their head a neurological assessment was undertaken. Ongoing wound assessments are sighted for residents requiring wound care management. Medical assessments occur in a timely manner when deemed necessary by the RN.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans sampled were integrated, and included the needs identified by the interRAI assessments, and the resident's generic overall needs regarding activities of daily living. Care plans did not detail the nursing interventions required to manage specific medical conditions, medication risks or any acute problems that arose. Progress notes captured the day to day care that was being provided, however care plans did not evidence service integration with progress notes, or medical and allied health professional's notations. GP consultation notes were not always kept at Camellia, and not accessible to care staff or available to inform the care plan. These are areas identified as requiring corrective action. Any change in care required was documented in the progress notes and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care provided.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents at Camellia was consistent with their needs and goals. The attention to meeting a diverse range of resident's individualised needs was evident in resident's progress notes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Evidence is sighted of timely referrals to the appropriate services as needed ie urology, radiology, eye clinic, mental health services for older people, wound care nurse specialist and acute services. Care staff confirmed that care was provided as outlined in the handover report, or by verbal instructions from the RNs. A range of equipment and resources was available, suited to the level of 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	The activities programme at Camellia is provided by two activities coordinators, who both work part time and ensure activities are provided five days a week. The planned activities are meaningful to the residents and is determined by a social assessment on admission. Activities assessments are regularly reviewed to help formulate the activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review. The activities programme covers physical, social, recreational, emotional and cultural needs of the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include a daily exercise programme, regular outings to participate in community events, coffee mornings, swimming sessions, and men's club, a number of local clubs, visiting entertainers, quiz sessions and daily news updates. Residents are assisted to maintain their contacts with their community groups. The activities programme is discussed at the monthly residents' meetings and minutes indicate residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the

		programme. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Where progress is different from expected, the RN directs the care staff and initiates changes. Changes are requested in the progress notes. Relatives and staff input are sought in all aspects of care There is no evidence sighted of care plans being evaluated by the RN, in a comprehensive and timely manner. This is an area requiring corrective action. Acute care plans are used for infections and wound care only. Examples were sighted of acute care plans for infections being reviewed. A wound care plan for a resident with a chronic wound has no evidence of an evaluation of the wound care plan since May 2019. Interviews with the RN identified the present care plan system in place does not require a documented evaluation to be recorded. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
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	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the nursing staff or GPs. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	Policies and procedures related to waste are documented and comply with legislation and local authority by laws. Staff interviews,

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		observations and visual inspection of all areas revealed that there are no hazardous substances stored on site. Household and biological waste is disposed of appropriately. A sharps collection box is stored securely and incontinence products are placed in an outside receptacle for weekly collection and disposal. There is minimal food waste and the management of this and/or other organic waste complies with environmental guidelines. There have been no residents with known transmissible diseases. All body waste is handled using standard and universal precautions. A designated bin for infected waste is stored outside and staff understood when to use it. Staff were observed to be using hair nets, aprons and gloves when engaging in food handling, personal cares, cleaning or laundry tasks.
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 is on display which expires 22 June 2020. Electrical inspections of plug in appliances is carried out bi-annually. This occurred in August 2018 and is due again August 2020. Medical equipment such as the blood pressure monitor, oxygen concentrator, temperature scan, seated scales and hoists are checked annually. Records of this occurring in February 2019 were sighted. The interior and exterior of the buildings are in good condition. There were no observable hazards on site and no incidents have occurred related to the environment. The grounds are pleasant and safe with no steep inclines. Suitable seating and shade is provided. The prospective purchaser has no plans to make changes to the buildings or the physical environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All of the 30 bedrooms are fitted with hand basins. Thirteen bedrooms have their own ensuite bathrooms, three have toilets and the other fourteen have easy access to communal bathrooms which are within close walking distance. The residents interviewed were happy with the provision of ablutions. Hot water temperatures are tested monthly by the owner/operator. Records show steady safe temperatures delivered at the taps

		accessed by residents.
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	All rooms are spacious and can easily accommodate the use of mobility equipment along with two staff and a resident at the same time. Residents are encouraged to bring in their own furniture. The rooms inspected were personalised with a mix of the resident's furniture and what is provided by the home, televisions, radios, storage and armchairs. These were individually decorated. All residents expressed satisfaction with their bedrooms.
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	The home has a large lounge close to the main door and a smaller lounge area in another wing which is used by all residents and/or their visitors at different times of the day. Day time activities for residents who wish to participate are on offer in the main lounge. The majority of residents also had televisions and radios in their room for individual relaxation or private time. There is a communal dining room and some residents choose to take their meals to their bedrooms. The furniture provided is in good condition and suitable for older people. The home has plenty of external sitting areas and gardens which residents enjoy sitting in. Visitors tend to meet with residents in their bedrooms.
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	Cleaning and laundry is provided by nominated staff who are allocated specific hours and tasks each day. The effectiveness of cleaning and laundry is audited regularly by the facility manager and resident feedback is encouraged. All areas of the home were assessed as clean and the relatives interviewed stated the home and their family's bedrooms were always clean and tidy. Staff confirmed they have been provided training in the safe handling of cleaning chemicals. The chemicals were being stored safely and securely with the cleaning trolleys and equipment kept locked in a designated cupboard. Chemicals are decanted into labelled containers from bulk dispensers. Material safety data sheets for each chemical is

		on site and located where the chemicals are stored. Laundry processes were observed to be effective, safe and hygienic. A dedicated laundry staff member attends to all the laundry needs such as personal clothes, bed linen and towel's but not the kitchen laundry. This staff member said sufficient hours were allocated. The residents and family members interviewed stated they were satisfied and grateful for the cleaning and laundry services provided. The facility does not have a separate sluice room but each wing has a cupboard space for mop rinsing. Residents who need ready access to toileting in the night are allocated bedrooms with ensuite toilets.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved fire evacuation scheme for the building dated 2012 and trial fire evacuations are occurring at least six monthly. The most recent planned fire drill occurred in July 2019 and another is scheduled for next week. The results of trial evacuations are recorded and show how long it took to clear the building and any issues that arose. A hard-wired fire suppression system (sprinklers and smoke detectors) are installed, the building design includes fire cells and exit signs are clearly displayed. The civil defence kit inspected on site contains essential emergency supplies and equipment and is checked regularly. A 3,000 litre water storage tank is on site. This adheres to the Ministry of Civil Defence and Emergency Management recommendations for emergency water storage in the Waikato region. There is sufficient food available for the needs of 30 residents for three to five days. Gas barbeques are stored ready for cooking in the event of power outage. There is no generator or emergency lighting system, but plenty of portable torches and batteries are in the civil defence kit. The call bell system is functional, and staff were observed to respond to the bell immediately. Residents and family members said staff were always attentive and responsive. Interview with the owner/operator and staff confirmed that security checks of all doors and windows occurs each day at dusk. There have been no security incidents since the previous audit.

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	All areas of the home have sufficient natural light. Each bedroom has large opening windows and the communal areas have ready access to outside. The bedrooms are individually heated by panel heaters and hallways and communal areas are heated by electrical central heating. There are surplus quilts and blankets for additional warmth in the event of an electrical power outage. The residents interviewed confirmed the temperature in the home are comfortable all year round. There have been no complaints or issues raised about temperatures in the resident's meetings nor in the building maintenance logs.
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	Camellia provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the FM, quality co-ordinator (QC), and the RN. The infection control programme and manual are reviewed annually. The role of the infection control coordinator (ICC) is held by the RN who has access to external specialist advice from the GP practice and WDHB infection control specialists when required. A documented role description for the RN, includes responsibility for ICC. Infection control matters, including surveillance results, are reported monthly to the RN and FM and tabled at the monthly staff meetings and the three-monthly management meetings. Infection control statistics are entered in the organisation's electronic database. Signage at the main entrance to the facility requests 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 interviewed demonstrated an understanding of the infection prevention and control programme.

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 (ICC) with support from the QC has appropriate skills, knowledge and qualifications for the role and is responsible for implementing the infection control programme. The QC has undertaken training in infection prevention and control as verified in training records sighted. Well-established local networks with the infection control team at the WDHB are available and expert advice is available if required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Collation, analysis and reporting of infection are discussed and explained at the management quality meetings and monthly staff meetings. The RN confirmed the availability of resources to support the programme and any outbreak 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 requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Camellia has documented policies and procedures in place that reflect current best practice. Policies were reviewed within the last year and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the contracted quality coordinator and other specialist consultants. A record of attendance is maintained and was sighted. The training content meets best practice and guidelines. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in

		urinary tract infections. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
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 size and complexity of the service. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICC, QC and FM review all reported infections. All infections are recorded on the infection register, this information is collated, reviewed and analysed by the FM who will advise staff and management of the outcome. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Surveillance programme is reviewed during the infection control programme review.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Camellia Rest Home has a philosophy and practice of no restraint. There were no restraints in use on the days of audit. Six residents were using bed levers as enablers. These were listed on the enabler register, and described in each residents care plan. The resident files contained an agreement and consent signed by the resident that these were voluntary. The restraint minimisation and safe practice policy clearly defines the difference between restraint and enablers, and forms and processes are available if a restraint is required. An RN is designated as having overall responsibility for the service approach to restraint/enablers. The sample of staff records reviewed showed that training in the prevention of restraint use, managing falls and challenging behaviours

		occurs at least annually.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The facility manager coordinates the internal audit schedule, and the internal audits are allocated across all staff. There were inconsistencies in the audit reports, for example findings and recommendations were not always described. The owner who attends all staff meetings said the facility manager reviews the audit and incident reports and presents these at staff meetings for discussion. The records for this did not clearly show what corrective actions had been decided, who was responsible for implementing the improvements or whether improvements had occurred. The documents related to internal audits, incidents reports and minutes from staff and management meetings fail to provide evidence that issues identified have been	There is insufficient evidence that gaps identified via internal audits or incidents/accidents are being followed up/rectified.	Document evidence that corrective actions have been implemented and that the problem/gap has been resolved. 90 days

		rectified.		
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	Two significant incidents and a recent resident injury had not been documented in the incident reporting system. In July a resident was administered a different controlled drug than what was prescribed (refer to finding in 1.3.12).This error was not included in quality and risk data and there was no documented evidence that a review of the processes that lead to the wrong medicines being administered had occurred. Two care staff were issued a performance warning and undertook training when in fact they were following a verbal instruction by the RN at the time. The causative factors had not been fully investigated. In the second incident the fire alarm was activated at night which was attended to by the local fire brigade. According to the owner the sole night staff person followed procedure but other staff said the fire service expressed concern. No written account of the event or review of the incident could be located. A resident known to be a high falls risk was observed to have a skin abrasion from an unknown cause but this was not documented in the incident report system. Another incident related to the total amount of controlled drugs dispensed from the pharmacy was documented, but the event was not clearly described in the incident report.	Not all incidents are being documented, reported, investigated and reviewed according to the accident/incident policy.	Provide evidence that all incident and accidents are clearly documented and reported in order to identify improvements and to manage risk. Where necessary ensure that a formal investigation and review of occurs 60 days
Criterion 1.3.12.1	PA	A medication error concerning a controlled	Improvement is required	Provide evidence that the

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	Moderate	drug, identified inaccuracy in checks by two medication competent staff members, and the wrong drug being given to a resident. This was recorded in the residents progress notes, however no incident form had been documented (refer criterion 1.2.4). An observed medication round saw two nurses check the controlled drug out, verify the check, sign the register and sign the administration record. The second checker did not go to the bedside and was unable to verify the correct resident received the medication. On interview both care staff denied being aware this was required. An injection being administered three monthly, yet prescribed two monthly on the medication chart, and the label on the medication requesting it be given monthly, had not been picked up during previous medication administration checks. The controlled drug register has no evidence of the required June and December quantitative stock takes occur. The medication room has no evidence the temperature remains within the required range for safe storage of medicines.	around the process of ensuring staff understand the process of safe medication management and are competent to administer medications. The controlled drug register does not evidence the occurrence of quantitative stocks checks six monthly, on June 30, and December 31. The medication room is not evidenced to be monitored to ensure the temperature is within the required range to store medicines.	competency of staff to ensure safe medication management has been reviewed and verified as safe. Provide evidence the required checks of the controlled drug register occur, and the temperature of the medication room is monitored to ensure storage of medicines is at the correct temperature, 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment	PA Moderate	Six of six files reviewed identified the generic needs of the resident regarding meeting their day to day needs. However, the required nursing interventions to monitor for ongoing risks associated with the resident's medical conditions, individualised needs, medications,	Care plans do not describe fully the care the resident requires to achieve their desired outcomes.	Provide evidence the resident care plans fully reflect residents support needs.

process.		changing needs or ongoing risks are not documented in the care plan. Two residents with an increase in recent falls, has no update to the care plan regarding acknowledgement this has occurred, what action has been taken to identify possible causes and any changes in care required to minimise the risk. A resident on an anti-coagulant, has no record of this in the care plan, the potential risks, and nursing strategies to manage the risk. A resident on a fluid balance chart to monitor fluid intake has had this discontinued, however the care plan has not been updated. A resident with a behavioural issue, input from specialist and the commencement of medication to assist with the behaviour, has no record of a behaviour management plan, despite having a behavioural monitoring record in place that is inconsistent with the records in the progress notes. Residents with chronic obstructive airways disease have no documentation in the care plan, acknowledging the condition and the required nursing interventions to monitor the resident. Interviews with the RNs and care staff verified this evidence.		60 days
Criterion 1.3.5.3 Service delivery plans demonstrate service integration.	PA Moderate	The GP either visits the residents at Camellia or the resident is taken to the Medical Centre. Four of six resident files had verification of the GP visit, recorded by the RN in the resident's progress notes, with any GP orders recorded. There is no	Service delivery plans do not reflect integration of services. There is no documentation onsite of GP consultations, findings or requested actions	Provide evidence a system has been implemented to ensure residents GP consultation notes are on site at Camellia.

		documentation onsite by the GP, to verify the GPs visit, findings or the requested actions. In some cases, the GP ticks a sheet and signs to verify the resident is stable and can be reviewed three monthly. The RN has no documentation to clarify the GPs request, or authorise the required actions.	in four of six files reviewed.	30 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Resident care is evaluated on each shift and reported by the care staff in the progress notes. Any concerns are reported to the RN, and any changes required documented in the progress notes by the RN. A review of six resident files evidenced no documented evaluation of the resident's plan of care being undertaken by the RN, every six months in conjunction with the interRAI reassessment or as residents needs change. Acute care plans are used for infections and wound care only. Examples were sighted of acute care plans for infections being reviewed. A wound care plan for a resident with a chronic wound has no evidence of an evaluation of the wound care plan since May 2019. Interviews with the RN identified the present care plan system in place does not require a documented evaluation to be recorded. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.	There is no evidence of formal care plan evaluations occurring in six of the six files reviewed.	Provide evidence the RN evaluates residents care plans within appropriate timeframes to indicate the degree of achievement to reach the residents desired outcome. 60 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.