

Elms Court Lifecare Limited - Maidstone Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Elms Court Lifecare Limited
Premises audited:	Elms Court Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 November 2019 End date: 7 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:	31

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
Yellow	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
Red	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

Elms Court Lifecare has been privately owned and operated since January 2019. The service provides care for up to 32 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 31 residents in total.

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

The owner/manager operates another rest home facility in the area. He is supported by an experienced clinical manager and stable workforce. Residents and relatives interviewed were complimentary about the care and services provided under the new ownership.

This certification audit identified an area for improvement around service delivery documentation.

The service has achieved continuous improvement ratings for good practice and reduction in urinary tract infections.

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.

All standards applicable to this service fully attained with some standards exceeded.

Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are encouraged to maintain links with their community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meet current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The owner/manager is supported by a clinical manager who is a registered nurse and is on site five days a week and is on call when not on site. They are supported by a team of RNs and care partners.

There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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

The service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Registered nurses are responsible for all stages of service provision. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care.

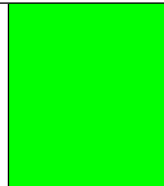
The lifestyle coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. Electronic medication charts have photo identification and allergy status noted. Medication charts are reviewed three monthly by the general practitioner.

All food and baking is done on site. The menu has been reviewed by a dietitian. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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.

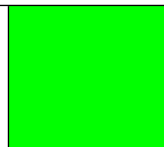


Standards applicable to this service fully attained.

There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current warrant of fitness. Resident rooms and communal bathroom facilities are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. All communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. There is one person on duty at all times with a current first aid certificate. Laundry services are completed on site. Staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

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

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.

All standards applicable to this service fully attained with some standards exceeded.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

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	2	42	0	1	0	0	0
Criteria	2	90	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policy relating to the Code is implemented. The facility manager/owner, the clinical manager, two RNs, the activity person and three care partners interviewed could describe how the Code is incorporated into their everyday delivery of care. Other staff, including: the cook, a kitchen assistant, and the maintenance person were also able to describe the Code of Rights. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Six resident files (four hospital including one resident on an end of life contract and one resident under ACC funding and two rest home residents including one under a serious medical illness contract) were reviewed and included signed general consents. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Advance directives where available, are acted upon. Resuscitation status were signed appropriately. Family members interviewed stated they were consulted in decisions that affected their relative's lives.</p>

consent.		Residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. The resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Health and Disability Commissioner (HDC) advocacy details are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services. A record of complaints received is maintained by the owner/manager. Nine complaints have been lodged in 2019 (year-to-date) and were reviewed. Complaints are being managed in accordance with HDC guidelines. Two complaints were lodged through the DHB; one around the care of one resident and one around the use of premium rooms. Both complaints have been fully resolved. Complaints follow-up was noted to be very well documented and discussed in the quality meetings. Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.
Standard 1.1.2:	FA	Details relating to the Code and the HDC advocacy service are included in the resident information that is

<p>Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>provided to new residents and their families. The owner/manager, the clinical manager or an RN discusses aspects of the Code with residents and their family on admission. All five residents interviewed (three hospital and two rest home) and six family members interviewed (two rest home and four hospital), reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' personal belongings are used to decorate their rooms. The care partners interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being provided and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect as part of the services training days each year (last provided October 2019).</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health policy is documented for the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There were no residents living at the facility who identified as Māori. The service is able to access cultural assistance through the DHB if needed.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as an annual training topic.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all six care plans reviewed. Residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>

which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions and as part of the staff code of conduct. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the care partners' role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The owner/manager and clinical manager are on site five days a week and are supported by a team of RNs. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Resident meetings are held two-monthly. Residents and family interviewed reported that they are very satisfied with the services received. This was also confirmed in the 2019 resident/family satisfaction survey.</p> <p>Physiotherapy services are provided two hours a fortnight and as needed and a physiotherapy assistant (employed) is on site three days a week. A podiatrist visits the facility every six weeks.</p> <p>The environment allows for close relationships between the staff and residents.</p> <p>Service specific improvements have included the reduction of falls.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy around open disclosure which is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Twelve accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There were no residents at the facility who were unable to speak or understand basic English. One family assisted with one resident for more in-depth conversations such as with the GP.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Elms Court Lifecare provides rest home and hospital (geriatric and medical) levels of care for up to 32 residents. On the day of the audit there were 31 residents. This included: 13 residents at rest home level care including one resident funded through severe medical condition (SMI) contract. There were also 18 residents at hospital level care including one on an end of life contract and one ACC.</p> <p>A philosophy, mission, vision and values are in place. The business plan (2019) was reviewed in May by the manager/owner of the facility.</p> <p>The manager/owner has owned the service since the beginning of 2019. He has over eight years' experience of owning and managing healthcare services including a sister facility he also owns; this facility has a separate manager. He has maintained a minimum of eight hours of professional development per year relating to the management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>There is a clinical manager who is responsible for clinical operations and undertakes the overall management in the absence of the facility manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management system is understood and being implemented as confirmed during interviews with the owner/manager and staff.</p> <p>Policies and procedures align with current good practice and meet legislative requirements. Policies have been reviewed, modified (where appropriate) and implemented. Reviews take place two yearly or when policies are updated. A document review schedule is in place. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Quality data and outcomes are discussed with staff in the two monthly staff and quality meetings. Two monthly resident meetings are completed and also open to families to attend.</p>

		<p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, specialised care plans and additional training for staff.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations are not always conducted for suspected head injuries (link 1.3.6.1).</p> <p>The facility manager is aware of statutory responsibilities in regard to essential notification with no essential notification required since the new owner purchased the service.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (three care partners, two RNs, one activities person and the clinical manager) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that new staff were adequately orientated to the service.</p> <p>An education and training programme is provided for staff that meets contractual obligations. In-service training is offered to staff in two blocks each year. Each block is repeated twice to enable as many staff as possible to attend. Education documentation reviewed, included all compulsory subjects and had a high attendance rate (100% of staff). Additional training was evidenced through meetings and ad hoc training.</p> <p>Competencies are completed specific to worker type and include medication competencies annually. A register of current practising certificates for health professionals is maintained. Eight of nine RNs, including the clinical manager, have completed their interRAI training. Registered nurses and caregivers have received ongoing training that relates to the provision of hospital (medical) level of care including palliative care, falls management and manual handling techniques. Training records demonstrated that when a resident is admitted with a care</p>

		need that is not familiar to staff, immediate training is given in brief form, prior to or at the time of admission.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. The owner/manager and clinical manager are on site five days a week and available on-call. Care partners interviewed stated that the management and registered nurses were very supportive and available to them.</p> <p>On the days of audit there were 31 residents (13 rest home and 18 hospital).</p> <p>There is an RN on duty for each shift seven days a week.</p> <p>For care partners the staffing is: AM - two long shifts and two short shifts. PM - three long shifts and one care partner at night.</p> <p>A lifestyle coordinator is rostered five days a week. There is also a physiotherapy assistant Monday to Wednesday. There are housekeeping and kitchen staff.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrated service integration. Entries were legible, dated, timed and signed by the relevant care partner or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has</p>	FA	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. The clinical manager screens all potential residents prior to entry to ensure the service can meet the assessed needs of the resident. Six admission agreements reviewed aligned with the requirements of the ARRC contract.</p>

been identified.		
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. A transfer form accompanies residents to receiving facilities. The residents and their families are involved for all exits or discharges to and from the service. The clinical manager and RNs interviewed were knowledgeable in the transfer/discharge process.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. Registered nurses and level four care partners administer medications. Medication education and medication competencies have been completed annually. All medications are stored safely. The service uses a four-weekly robotic roll system for regular medications and blister packs for 'as required' medications. All medications delivered are checked against the electronic medication charts and recorded in the resident medication chart when checked in. There were no self-medicating residents on the day of audit. The medication fridge is monitored daily and maintained within the acceptable temperature range. The medication room air temperatures are taken and recorded daily. All eye drops were dated on opening.</p> <p>Eleven medication charts on the electronic and one paper-based hospital script reviewed met legislative requirements. All residents have individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Medication administration was observed to be compliant with policy and practice.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a food services policy and procedure manual. The food control plan expires 18 February 2020. Food services staff have completed food safety and hygiene training. All meals are cooked on site by cooks who are supported by morning and afternoon kitchenhands. The four weekly seasonal menu has been reviewed by a dietitian October 2018. The cook receives a dietary profile for each resident and is informed of any changes in dietary requirements. Resident dislikes and food allergies are accommodated. Soft/pureed meals and vegan diets are provided. Meals are held in a bain marie until served to residents in the adjacent dining room. Meals to residents in rooms are plated and kept hot with insulated lids. Specialised utensils and lip plates are available as required.</p> <p>Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. Fridge and freezer temperatures are monitored and recorded. End cooked temperatures are taken and recorded on all meals. Chilled inward goods have temperatures recorded on delivery. The chemical provider checks the dishwasher for</p>

		<p>effectiveness. Chemicals are stored safely in the kitchen. The cleaning schedule is maintained.</p> <p>Residents have the opportunity to feedback on food services through resident meetings and surveys. Residents and family interviewed were complimentary about the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial assessments and risk assessments were completed on admission for all resident files reviewed including the resident on end of life contract. InterRAI assessments were completed within expected timeframes for long-term residents including the resident under ACC and the resident under SMI. The outcomes of the interRAI assessment and risk assessments were reflected in the long-term care plans reviewed. The end of life resident had an initial assessment and did not require a long-term care plan. Additional assessment for falls, pressure injury prevention, nutrition, pain, continence, behaviour, wound care and behaviour were utilised as required.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed for long-term residents (including the ACC and SMI resident) described the individual support and interventions required to meet the resident goals. Initial care plans were developed on admission in all resident files reviewed. The long-term care plans reflected the outcomes of risk assessment tools and the interRAI assessment. Short-term care plans were in use for changes in health status. These are evaluated regularly and either resolved, or if an ongoing problem, added to the long-term care plan. Residents/relatives interviewed confirmed they participate in the care planning process. Care plans demonstrated service integration and included input from allied health practitioners. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, adult rehabilitation service, ACC, older person health services, dietitian and podiatrist.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the RN initiates a review and if required a GP review. There is documented evidence on the family contact forms in each resident file, that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. The RNs interviewed can initiate referrals to specialists such as speech and language therapists, wound care specialists, and the Nurse Maude service. The GP initiates medical referrals. One resident with behaviours of concern did not have de-escalation techniques included in the care plan. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. There is a support worker who spends one-on-one time daily with the SMI resident.</p> <p>Wound management policies and procedures are in place. A wound assessment and short-term care plan and wound dressing application record and evaluations were in place for 10 wounds (skin tears, lesions and two surgical wounds). Wounds had been evaluated at the documented frequency. There were two facility acquired stage two pressure injuries and one stage two community acquired pressure injury on the day of audit. There was adequate pressure relieving equipment available and staff had received education around the prevention of pressure injuries. The GP reviews all wounds and the Nurse Maude wound specialist is available for support and advice.</p> <p>Adequate dressing supplies were sighted, and continence products are available. The residents' files included a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for food and fluids, pain, enabler monitoring and challenging behaviours, however neurological observations had not been completed for all unwitnessed falls. The electronic medication system is well utilised for the recording of weights, blood pressure, vital signs blood glucose and the GP notes are also entered into the system.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a lifestyle coordinator who is currently progressing through the diversional therapy qualifications. She works Tuesday to Saturday from 9 am to 4.30 pm. She is supported by the physiotherapy assistant for the exercise programme (link 1.1.8.1). The monthly programme is developed in consultation with residents and reflects their interests and abilities. The integrated programme is varied and provides group and individual activities to meet the hospital, and rest home residents' recreational preferences and interests. A support worker accompanies the SMI resident on outings and activities of their choice. Care partners incorporate activities into their role on the lifestyle coordinator days off. One-on-one contact is made with residents daily, who are unable to or choose not to participate in group activities. Individual activities include hand massage, chats, reading etc. Room visits are made daily to residents, ensuring they are aware of the activities being offered. Activities include (but are not limited to); daily exercises, newspaper reading, hand massages, quizzes, board games, music, art and crafts, bowls, mini golf, movies, walks and gardening. Community visitors include church visitors and entertainers, kapa haka group, pre-school, school children and girls brigade groups. The service has a wheelchair hoist van and there are weekly outings to community events such as performances, concerts,</p>

		<p>shopping, cafes, lunches and inter-home visits to Elms Court rest home. There are scenic drives and picnics. Themes and festivities are celebrated.</p> <p>There are two pet dogs and a cat who live on site and the manager's dog visits daily adding to the homely atmosphere.</p> <p>Residents have a social profile and interests and hobbies form completed over the first few weeks after admission, which forms the basis of an activities plan which is then reviewed six monthly. A record is kept of individual resident's activities and monthly progress notes are documented. Resident and relative meetings are held two monthly and provides an opportunity for residents and relatives to feedback on the service and the activities programme. Residents and relatives interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five long-term care plans were reviewed. Four long-term care plans had been evaluated by RNs six monthly. One rest home resident had not been at the service long enough for a care plan evaluation. There are written evaluations that identify if the resident goals have been met or unmet. There are three-monthly clinical reviews by the medical practitioner or sooner if needs change. Short-term care plan evaluations are completed at weekly intervals or more often if required. Evaluations are conducted by the RNs with input from the resident, family, activities coordinator, care partners and GP. Family are notified of any changes in the resident's condition, as evidenced in resident files reviewed and confirmed in family interviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services. There is documented evidence of referrals to the podiatrist, physiotherapist, dietitian, older person health service and hospice. Referrals are made to needs assessors for re-assessment of level of care as evidenced for one rest home resident who was re-assessed for hospital level of care and one resident who was re-assessed from respite to rest home level of care.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets were readily accessible for staff. Chemicals were stored</p>

<p>And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>safely throughout the facility. Personal protective clothing was available in the sluice, laundry and cleaning rooms. Staff were observed to be wearing appropriate protective clothing when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires on 1 June 2020. The maintenance person has been in the role two years and works 33 hours a week in maintenance and does one cleaning shift mid-week. A maintenance request logbook is kept in the nurses' station (sighted) which is checked daily with requests signed off when completed. There is a scheduled maintenance plan in place that includes internal and external maintenance, testing and tagging of electrical equipment and calibration/functional checks of resident related equipment. Essential contractors are available 24-hours. The maintenance person has completed a qualification for electrical testing and tagging of equipment. There are weekly hot water checks and room air temperatures taken and recorded. All resident basins and showers have had individual thermostat tempering valves installed and hot water temperatures are maintained below 45 degrees Celsius.</p> <p>The facility has sufficiently wide corridors with handrails for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade are provided. Family members maintain the garden and grounds. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The care partners interviewed stated there was sufficient equipment (hoists, pressure relieving devices and weight scales) to safely carry out the cares as documented in care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to</p>	<p>FA</p>	<p>All resident rooms have hand basins. There is one resident bedroom with an ensuite toilet. There are sufficient communal toilets and showers to meet resident requirements. All communal toilets and bathrooms have appropriate signage and locks on the doors. Fixtures, fittings and flooring is appropriate.</p>

personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident rooms are spacious enough to allow residents to move about with mobility aids and wheelchairs and allows for the use of hoists. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Residents were observed safely moving around the facility. There was sufficient space to transfer residents from room to lounge in specialised hospital lounge chairs.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There is a main large lounge and a smaller lounge available for quieter activities or visitors to use. There is a separate dining area adjacent to the kitchen. Group activities occur in the main lounge, and residents interviewed stated they were able to use alternative communal areas if they did not wish to participate in communal activities being held in one of these areas. There is safe access to the gardens and grounds.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the</p>	FA	<p>There are policies and procedures in place for laundry and cleaning services. Elms Court Lifecare has reinstated on site laundry for all personal clothing and linen as from February 2019. The large office/storage area (previously a purpose-built laundry) has been converted back to the laundry room with new commercial washing machines and dryers (still under warranty). There is a defined clean/dirty area with two door entry/exit. There is an external opening door for adequate ventilation. Input into the layout of the laundry was sought from the clinical manager and infection control coordinator. Care partners carry out laundry duties throughout their duty with night staff completing folding and ironing as required. Staff wear pagers that alert them to call bells.</p> <p>There is a cleaner on duty seven days. Cleaning trolleys are kept in a locked cleaner's cupboard when not in</p>

<p>setting in which the service is being provided.</p>		<p>use. Chemical bottles on the trolley were labelled correctly and refilled through a mixing system. Cleaning equipment is colour coded. A cleaning schedule is maintained. Safety data sheets and product information is readily available. The cleaning and laundry service are monitored through the internal auditing system and resident satisfaction surveys. The effectiveness of laundry and cleaning services and chemicals used is also monitored by the chemical provider.</p> <p>Residents and relative interviewed were satisfied with the laundry and cleaning service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures and a civil defence plans are documented for the service. Fire drills occur every six months (at a minimum) with the last fire drill taking place on May 2019. The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A disaster management plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas cooker is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly by maintenance.</p> <p>There is always at least one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. All staff are required to complete their first aid training.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas are heated by large heat pumps and there is underfloor heating throughout the facility. All resident rooms have external windows and are well ventilated. The facility has plenty of natural light. All residents interviewed, stated they were happy with the temperature of the facility.</p>
<p>Standard 3.1: Infection</p>	<p>FA</p>	<p>Elms Court Lifecare has an established infection control programme. The infection control programme has been reviewed for 2019. The infection control programme, its content and detail, is appropriate for the size, complexity</p>

<p>control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>and degree of risk associated with the service. It is linked into the incident reporting system. An RN is the infection control coordinator. The infection control coordinator has support from all staff including the GP. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the GP and IC team at the DHB. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and hand sanitiser is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures</p>	<p>FA</p>	<p>Elms Court Lifecare has infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies were introduced with the new ownership.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff and has completed an online infection control course. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Resident education occurs at resident meetings such as use of sanitisers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at two monthly meetings. If there is an emergent issue, it is acted upon in a timely manner. The service has reduced the incidence of urinary tract infections. Overall infection rates are low and there has been no outbreak since previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. There were no residents using a restraint and one resident with a lap belt enabler in use. The resident with an enabler had a documented assessment and consent. The care plan included the enabler and risk associated with its use. Monitoring had been completed as per the care plan.</p> <p>Staff receive training on restraint minimisation. The care partners and RNs interviewed were able to describe the difference between an enabler and a restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Monitoring forms are completed for monthly weights and vital signs. There are other monitoring forms available as required for food and fluids, pain, blood sugar levels and challenging behaviours, however neurological observations had not been completed as required. One rest home resident (SMI) with behaviours of concern did not have de-escalation techniques included in the care plan.	(i) Neurological observations had not been completed as required by policy for four of six unwitnessed falls reviewed, and (ii) there were no interventions documented for the management/de-escalation of potential behaviours of concern for rest home SMI resident.	<p>(i) Ensure neurological observations are completed as per policy, and (ii) ensure interventions and de-escalation strategies for behaviours of concern are included in the behaviour management plan.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has a quality meeting committee that meets two monthly. All quality data including the incidence of falls is reviewed at this meeting. Where required, corrective action plans are developed. The meeting noted a high incidence of falls with an increasing trend between March and May 2019. A plan was implemented to address the high incidence of falls.</p>	<p>During March to May the incidence of falls increased from four a month (March) to sixteen a month (May). A process was put in place to reduce falls and improve resident safety. This included (but not limited to): discussion of falls strategies in the RN meetings, reviewing all individual falls and the development of falls management plans for all identified frequent fallers. A physiotherapy assistant commenced an activity programme three times a week and all moving and handling programmes for residents were reviewed by the physiotherapist. The service has also worked with the staff to engender a “can do” approach and care partners are encouraged to be proactive with supporting residents in all aspects of daily care. Additional training was provided including follow up and discussion of falls at staff meetings. Falls have reduced in September to six with an overall downward trend since May.</p>
<p>Criterion 3.5.7</p>	CI	<p>The service has an infection control committee that meets two monthly, as a</p>	<p>The service implemented a plan to reduce the incidence of urinary tract infection. Interventions included (but not limited to); education for staff,</p>

<p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>		<p>subset of the quality management meeting. Surveillance data is reviewed at this meeting and, where required, corrective action plans are developed. The infection control committee reviewed the incidence of urinary tract infections. It was noted that urinary tract infections had risen from March 2019 (nil) to three in May 2019. A plan was put in place that effectively reduced the incidence of urinary tract infections.</p>	<p>residents and family regarding prevention of urinary tract infection and the importance of drinking plenty of fluids. Family and resident information was provided as part of care and also as part of resident/family meetings.</p> <p>The service reviewed staffing and noted that afternoon staff did not always assist with fluids due to other tasks. The kitchen assistant was assigned to assist with afternoon drinks and snack, and this ensured that the more dependant residents had more time to enjoy their drinks and snacks.</p> <p>The service reviewed continence products and changed to an alternative continence product, full training was provided to staff on the use of the new product.</p> <p>Over the period May 2019 to September 2019 the incidence of urinary tract infections has reduced in May to nil in July and one for August and September. This low incidence is remarkable as it includes two residents who have a supra pubic catheters and one with an indwelling catheter.</p>
---	--	---	---

End of the report.