

Sodhi Enterprises Limited - Coronation Lodge Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Sodhi Enterprises Limited	
Premises audited:	Coronation Lodge Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 9 December 2019	End date: 9 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:	19	

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

Coronation Lodge has been operating under new management for 10 months. Coronation Lodge Rest Home provides rest home level care for up to 22 residents. On the day of the audit there were 19 residents residing at the facility.

This certification audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff, management and general practitioner.

The facility manager/owner has held previous business management roles. The clinical nurse manager/owner was previously a clinical nurse specialist in rehabilitation for the older person. The managers are supported by a long-serving team. Residents and family interviewed were complimentary of the service they receive.

This certification audit identified improvements around staff references and care plan interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Coronation Lodge provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management plan and quality and risk policies describe Coronation Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned and untoward events are documented by staff. There is an implemented health and safety programme. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external

training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The clinical nurse manager is responsible for managing entry to the service. Service information is available to potential residents and families. Initial assessments, interRAI assessments, care plans and evaluations are completed by the clinical nurse manager within the required timeframes. Residents interviewed confirmed that they are involved in the care planning and review process. Resident files include allied health professional involvement.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting with a focus on community involvement and maintaining residents' past and present interests.

Medicines are stored and managed appropriately in line with legislation and guidelines. The RNs and senior caregiver's complete medication competencies and medication education. The general practitioner reviews the medication charts at least three monthly.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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.
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The building has a current warrant of fitness and emergency evacuation plan. There is one double room and all others are single. All rooms have handbasins and there are communal toilets/showers. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are well utilised for group and individual activity. The dining room and lounge seating placement encourages social interaction. Other outdoor areas are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely. The staff maintain a tidy and clean environment. Systems and supplies are in place for essential, emergency and security services. There is a civil defence kit and evidence of supplies in the event of an emergency in line with civil defence guidelines. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of approved restraints and enabler. Staff receive regular education and training on restraint minimisation. Restraint use is discussed at staff meetings. Internal audits monitor safe restraint use and compliance of policy and procedures. At the time of the audit there was one resident who required bedrails as an enabler for safety and three residents who required environmental restraint. Appropriate documentation supported its use. The remaining residents are able to freely come and go from the facility as they please.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (clinical nurse manager) is responsible for coordinating the infection control programme and providing education and training for staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	1	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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's (HDC) Code of Health and Disability Consumers' Rights (the Code) is being implemented at this rest home level aged care facility. Staff interviewed (one clinical nurse manager/RN (CNM), two caregivers, one recreation assistant, one maintenance, one laundry staff, one cleaner and one cook) could provide examples of how the Code is incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service. This training continues annually through the staff education and training programme with the last training taking place on 6 November 2019. Both staff and residents are invited to attend.</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>All five residents' files reviewed (including one younger person under long-term chronic health condition) contained signed general consent forms including for photographs, release of information and outings. Residents and family interviewed stated that they had been given adequate information to support them to make an informed choice. Resuscitation forms had been appropriately signed by the resident and general practitioner (GP). Where the resident was not competent to make an informed decision, the GP had made a medically indicated resuscitation decision. Copies of EPOA were on resident files and one had been appropriately activated by the GP. The service has been liaising with residents and families to implement advance directives. Three of five resident files contained advance care plans.</p> <p>Admission agreements sighted align with the DHB contract requirements and have been signed within</p>

consent.		required timeframes.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Health and Disability advocacy brochures 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. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice that aligns with Right 10 of the Code. A complaints register is maintained. Concerns/complaints are discussed during the monthly staff meeting as sighted in the meeting minutes. Complaints forms are visible within the facility.</p> <p>There have been five complaints lodged in 2019 (year to date). One of these complaints was lodged with the DHB around medication records, rosters, nutrition and residents' cares documentation. This complaint led to an issues-based audit by the Ministry of Health on 2 July 2019. Rosters and residents' cares were found to be partially substantiated and medication records and nutrition were unsubstantiated. A comprehensive corrective action plan was developed and implemented to address the findings and this complaint is now documented as closed. The remaining four complaints were also reviewed. There was evidence of acknowledgement of the complaint, an investigation and resolution of the complaint within the required timeframes as determined by HDC. Residents and families interviewed were aware of the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families during their entry to the service. The CNM and/or facility manager (both owners of the facility) discuss aspects of the Code with residents and their</p>

<p>Consumers are informed of their rights.</p>		<p>family on admission. Discussions relating to the Code are also held during the monthly resident meetings. Three residents and three family members interviewed 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>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed 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. Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service and was last provided on 13 May 2019. One instance of suspected abuse in 2019 required the owner's attention. Appropriate action was taken to address this allegation.</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>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. There are policies and guidelines to assist staff in the delivery of culturally safe care for Māori. The service has access to cultural advisors from Te Wānanga o Aotearoa New Plymouth who plan to visit the facility early in 2020 and provide cultural input and advice. Bilingual signage was evidenced throughout the facility. Staff are scheduled to attend a cultural in-service in January 2020.</p> <p>There was one resident who was Māori but did not identify any specific cultural values or beliefs, confirmed during an interview with a Māori caregiver and documented in his Māori care plan. This resident was unable to be interviewed. One Māori caregiver interviewed stated that Tikanga best practice is being implemented. All rooms are blessed following a death. The Code is available in English and in Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and</p>	<p>FA</p>	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in consultation with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family interviewed confirmed they were involved in developing the resident plan of care, which includes the identification of individual values and beliefs.</p>

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 also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, 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>	FA	<p>Examples of good practice were evident during the audit. The CNM, experienced in gerontology, is on site a minimum of 40 hours per week and is on-call when not available on site. She is supported by a second casual RN that covers in her absence. Resident/family meetings are held bi-monthly. Communication to families is also facilitated via regular newsletters. Residents and the relative interviewed reported that they are either very satisfied or satisfied with the services received. A resident/family satisfaction survey was initiated in November 2019. Three responses had been returned at the time of the audit and all were very positive. Interviews with caregivers confirmed that the teamwork amongst staff is very good. Two quality initiatives that have been implemented over the past year include celebrating the employee of the month, who is nominated by residents and boarders and offering a 'pop-up shop' for residents to allow them to make purchases for small goods they wish to have. Advanced care planning has been completed for 50% of residents and the facility has implemented Medimap to assist with medication management.</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 to guide staff on the process around open disclosure. Residents and families interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Fifteen incident forms reviewed identified family were notified following a resident incident. The facility manager, CNM and families interviewed confirmed family are kept informed (eg, incident/accident, doctor visit, change in resident's state of health). A family communication form is retained in each resident's file for the purpose of documented instances when families are kept informed.</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>Coronation Lodge provides care for up to 22 rest home level residents. There were 19 residents on the day of audit. One resident was on the long-term stay – chronic health conditions contract (LTS-CHC), and the remaining 18 residents were under the ARCC. An additional eight boarders live in separate accommodation adjacent to the aged care facility.</p> <p>The facility underwent a change in ownership on 4 March 2019. It was purchased by a couple who work as the facility manager and clinical nurse manager. The facility manager has previous management</p>

		<p>experience. His wife, the clinical nurse manager, is a registered nurse with ten years of experience in nursing in New Zealand. She previously held the role of clinical nurse specialist for older people's health at Taranaki Base Hospital. A 2019 business plan has been implemented that includes the service philosophy of care, quality goals, timeframes and responsibility. This business plan is regularly reviewed by the owners.</p> <p>Both the facility manager and clinical nurse manager have attended a minimum of eight hours of professional development over the past year relating to their respective role and responsibilities.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The CNM is responsible for business operations during the absence of the facility manager. A casual RN is responsible for clinical operations in the absence of the CNM.</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>The quality and risk management plan and quality and risk policies describe Coronation Lodge's quality improvement processes. The service contracts an aged care consultant who maintains and reviews policies to ensure they align with current good practice and meet legislative requirements. Policy updates are received, and staff are required to read and sign. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data (eg, infections, skin tears, falls, pressure injuries). Corrective actions are documented, implemented where improvements are identified and are regularly evaluated. Information including identifying trends, analysis and graphs are shared with all staff as confirmed in meeting minutes and during interviews. The internal audit programme monitors environmental and clinical areas. Corrective actions are generated and completed for any audit outcomes less than 100% and there was evidence of re-audits as part of the corrective action plan.</p> <p>The service has implemented a number of quality improvements and these are documented on a QI plan register including (but not limited to); involving residents in education sessions, introducing advance care plans, staff recognition certificates and careerforce training available to all staff.</p> <p>A risk management plan is in place. The owners hold a contractual relationship with an external company (Employsure) who assists them with implementation of health and safety processes. The health and safety</p>

		<p>manual was last updated in September 2019. A health and safety handbook is provided to all new staff who complete a health and safety competency during their orientation. The facility manager is the health and safety officer and has attended external health and safety training. The contracted physiotherapist provides staff manual handling training. Health and safety is discussed at the monthly staff meetings. Staff report hazards on hazard report forms and a hazard register is maintained. Actual and potential risks are documented on the current hazard register.</p> <p>Falls management strategies and the development of specific falls management plans are in place to meet the needs of individual residents who are at risk of falling. Residents at risk of falling are encouraged to wear hip protectors. Strategies implemented to reduce the number of falls for residents at risk include regular toileting, intentional rounding and sensor mats. The number of residents falling in January 2019 – April 2019 averaged 13.8 falls per month and the average falls per month for September – November 2019 was 5.5. There were no falls reported during the month of November.</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 including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme.</p> <p>Fifteen accident/incident forms were reviewed (one medication error, one skin tear, one breach of security, one absconding resident and eleven falls). There was timely RN assessment and follow-up including relative notifications, corrective action and GP review as required. Neurologic observations were conducted for suspected head injuries. The facility manager and CNM reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. Section 31 notification forms were completed in 2019 for one police investigation, one outbreak, and one issues-based audit conducted by HealthCert.</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>	PA Low	<p>Human resources policies are in place to support recruitment practices. Five staff files reviewed (one casual registered nurse, one CNM and three caregivers) contained evidence of signed employment agreements. Missing in a selection of the files was evidence of reference checking. Performance appraisals were current. Current practising certificates were sighted for the health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. All staff receive an employee handbook. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented and attendance records are maintained. There is an in-service topic each month in conjunction with the staff meeting. The RNs (CNM and casual) and caregivers complete a</p>

		range of competencies relevant to their role including (but not limited to) health and safety, abuse/neglect, diabetes, medication competencies, and a range of clinical skills. The CNM has completed her interRAI training.
<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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>At the time of the audit, there were 19 residents living in the care facility. RN cover is provided Monday – Friday with on-call cover when not available on site. A casual RN covers in the absence of the CNM. RN hours are documented on the staff roster.</p> <p>One long and one short shift caregiver (0700 – 0900) cover the AM shift seven days, a week a third (short shift) caregiver rostered five days a week from 0700 - 1300. A fourth (short shift) caregiver is rostered from 0800 – 1230 for laundry duties Monday – Friday. One long and one short shift caregiver (1530 – 2100) cover the PM shift and one caregiver covers the night shift. There are separate cleaning staff rostered Monday – Friday (0900 – 1430). A recreation officer is available from 0900 – 1430 Monday – Friday. A maintenance officer is available four days a week.</p> <p>The caregivers, residents and relatives interviewed informed there are sufficient staff on duty at all times.</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 into each resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Archived records are kept secure. Residents' files demonstrated service integration. Entries are legible, dated, timed and signed by the relevant caregiver 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</p>	FA	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents are assessed and approved for rest home level of care prior to entry. The clinical nurse manager screens all potential residents prior to entry. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager or the clinical nurse manager.</p>

<p>need for services has been identified.</p>		
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs in a timely and safe manner. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</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>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored safely. The clinical nurse manager, casual RN and senior caregivers who administer medications have completed medication competencies. Medications in robotic rolls are checked on delivery against the electronic medication chart. There were no self-medicating residents on the day of audit. The medication fridges and medication room temperatures are checked daily and within acceptable limits. All medications are prescribed and there are no standing orders. The supplying pharmacy is available after-hours.</p> <p>Nine electronic and one paper-based medication charts were reviewed and met prescribing requirements. All medication charts had photo identification and allergy status recorded. The outcomes of 'as required' medications were recorded in the electronic medication system.</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>	<p>FA</p>	<p>All meals are prepared and cooked on site by a cook who is supported by caregivers during serving of meals. There is a four-weekly seasonal menu which has been reviewed by a dietitian February 2018. The cook is informed of resident dietary preferences and notified of any changes to dietary requirements. Resident dislikes are known and accommodated. The menu is displayed daily with the main meal at midday. Pureed meals and diabetic desserts are provided.</p> <p>There is a current food control plan that expires 29 March 2020. Fridge, freezer, chiller temperatures, end cooked, cooling and serving temperatures are taken and recorded daily. All dry goods in the pantry were date labelled. Perishable food items in the fridge were date labelled. A cleaning schedule is maintained. All food services staff have completed food safety and hygiene training.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>	<p>FA</p>	<p>The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the level of care required.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed as part of the initial assessment. Outcomes of the first and six monthly interRAI assessments were reflected in the long-term care plans. Relevant assessment tools are used for any changes in resident health status, for example increase in falls and an action plan developed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The interRAI assessment process informs the development of the resident's care plan; however; not all long-term care plans reviewed described the support required to meet the resident's goals and needs. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Allied health professionals involved in the care of residents, complete notes which are reviewed by the clinical nurse manager.</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>FA</p>	<p>If a resident's condition changes the clinical nurse manager initiates a nurse specialist visit or GP consultation. Caregivers follow the short-term care plan and report progress against the goals in progress notes and at shift handover. There was documented evidence of relative notification on the family communication record held in the residents' files. Relatives interviewed confirmed they are notified of any changes to their relative's health.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessments/short-term care plans and evaluations were in place for five residents with wounds (including one chronic wound and one facility acquired stage one). Photos demonstrate the healing or non-healing process. There has been district nursing involvement in the chronic wound. The clinical nurse</p>

		<p>manager has access to the wound nurse specialist at the DHB.</p> <p>Interviews with the clinical nurse manager and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions, food and fluid monitoring, monitoring of bowels, monthly weights or more frequently as required, and regular (monthly or more frequently if required) weight management, behaviour charts and blood pressure monitoring.</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>	FA	<p>The service employs a recreational assistant for four hours a day 9 am – 1 pm Monday to Friday. The hours are flexible depending on the activities such as afternoon or evening events/outings such as the van outing through the festival of the lights. The recreational assistant and the clinical nurse manager are progressing through diversional therapy qualifications. The programme is planned a month in advance and the weekly planner is displayed on the board in the dining room. The weekend programme is delivered by care staff with some activities being resident led. The activity programme is planned around meaningful everyday activities and resident preferences including (but not limited to); variety of daily exercises, newspaper reading, discussions and reminiscing, word games, gardening, the walking group, happy hours and barbecues. The outdoor gardens are well utilised for resident gardening and watering of the raised vegetable beds. A “pop up shop” shop in the garden area was initiated for the residents in March 2019 and has continued to develop into an activity that residents look forward to. The residents have access to Wi-Fi for movies of their choice and “Alexa”.</p> <p>Community visitors include guest speakers such as St Johns and advocates, church visitors for hymn singing and communion, fortnightly entertainers, childcare pre-schoolers and pet therapy on Saturdays.</p> <p>The service has a wheelchair van and there are regular outings to church functions, Age Concern concerts and inter-home visits, preschool visits, shopping and lunches out.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activity plan in resident files reviewed reflected the specific requirements of each resident. A participation record is maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The clinical nurse manager evaluates all initial care plans within three weeks of admission. Files reviewed demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there was a change in health status. The written evaluation identifies if the resident goals have been met or unmet. The multidisciplinary review includes the clinical nurse manager, recreational assistant, facility manager, input from caregivers and the resident/relative as appropriate. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care</p>

		plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Examples of referrals sighted in files include diabetes nurse, urology, mental health services, geriatrician, cardiac nurse and Parkinson's specialist.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals are stored in an external locked shed and distributed to the areas as required. All chemicals sighted were labelled correctly and stored safely throughout the facility. There is one sluice room with appropriate personal protective clothing available. Safety datasheets are available. Staff have completed an on-line chemical safety course.</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>	FA	<p>The facility has a current building warrant of fitness which expires March 2020. The service is meeting the relevant requirements as identified by relevant legislation and standards. There is a second building on the site that houses private boarders and the facility manager's office. A maintenance person is employed five hours a day for four days of the week. Staff report repairs and requests into a maintenance book that is checked daily and signed off when repairs are completed. There is a weekly and monthly planned maintenance schedule that includes checks on resident mobility aids and hot water temperatures. Corrective actions had been taken where water temperatures were above 45 degrees Celsius. Essential contractors are available 24 hours a day.</p> <p>The physical environment allows easy access to communal areas for the residents and promotes independence for residents with mobility aids. The grounds and gardens are well landscaped. There are</p>

		<p>outdoor shaded areas and raised garden beds. There is a designated outdoor smoking shelter.</p> <p>Caregivers interviewed stated they had sufficient equipment to carry out the cares for residents as outlined in the care plans. There is a hoist available for resident falls.</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 personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of communal toilet and showering facilities. Privacy locks are in place. Vacant/in use signage is on the toilet/shower rooms. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares. All resident rooms have hand basins.</p>
<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	<p>There is one double room and all others are single. All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<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	<p>There is a dining room adjacent to the kitchen and a separate lounge for the residents. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	<p>There are designated persons who complete the cleaning and laundry service. The laundry person commences at 9 am following assisting with resident showers from 7 am to 9 am. There is a laundry person on duty seven days a week and a cleaner from Monday to Friday. There is an external laundry room with a defined clean/dirty area. There are commercial washing machines and a large dryer with line</p>

<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>drying also available.</p> <p>The cleaning trolley had all chemical bottles labelled and protective wear including plastic aprons and gloves. The chemical trolley is locked in the external chemical shed when not in use.</p> <p>Both staff interviewed could describe outbreak management processes for laundry and cleaning services. Residents expressed satisfaction with cleaning and laundry services.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire evacuation drills take place, last September 2019. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are adequate supplies in the event of a civil defence emergency including a 1000L water tank, barbeques and gas bottles, food storage, emergency equipment and battery back-up for emergency lights and call bells. The service is in the process of installing a generator.</p> <p>Emergency management is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is available at all times.</p> <p>There are call bells in the residents' rooms, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The building is secure after hours.</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 and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	<p>FA</p>	<p>The infection control (IC) programme is appropriate for the size and complexity of the service. The clinical nurse manager is the IC coordinator with a job description that defines the role and responsibilities for managing infection control across the service. The infection control programme is linked into the quality management system and discussed at weekly meetings with the facility manager, clinical nurse manager, recreational assistant/care coordinator, laundry person and cleaner. Infection control is discussed at staff meetings. The programme under new management is not yet due for an annual review.</p>

and visitors. This shall be appropriate to the size and scope of the service.		Visitors are asked to not visit if unwell. Residents are offered the influenza vaccine. Hand sanitisers are strategically placed around the facility.
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 infection control coordinator has access to an infection control nurse at the DHB, aged care consultant, GPs, laboratory staff and the public health team for support and advice as required.
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	There are infection control policies that are current and reflect the infection control standard SNZ HB 8134:2008, legislation and good practice. These are developed by an aged care consultant and regularly reviewed. The infection control policies link to other documentation and cross reference where appropriate.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The infection control coordinator has been a previous clinical nurse specialist and has appropriate knowledge to orientate and educate staff. The induction package includes specific training around hand washing and standard precautions and training is provided both at orientation and as part of the annual training schedule. Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.

<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>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly, analysed for trends and corrective actions and discussed at the monthly staff meeting. Meeting minutes and graphs are available to staff.</p> <p>There was a confirmed norovirus outbreak in September 2019. Contact and liaison with the Public Health department and notification to HealthCert were sighted. Information provided to staff, residents and families during the outbreak was sighted in the infection control folder.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. The restraint coordinator is the CNM.</p> <p>During the audit, there was one resident using an enabler (bedrail). Verbal consent for enabler use had been signed by the resident. The safe use of the enabler is reviewed three-monthly.</p> <p>The service has been DHB approved for the use of a keypad exit at the main entrance due to the proximity of a main road and to maintain safety for individual residents as assessed. The code is visibly available to residents and staff. There were three residents requiring environmental door restraint. Consent documentation had been completed by the residents' families. The remaining residents were able to freely come and go as observed during the audit. The security code for access is visible on the keypad when exiting the facility. No keypad access is required for entering.</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)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	All prospective applicants complete an application prior to undergoing an interview to determine their suitability for the role. The facility manager reported that reference checking is completed, although was not consistently being documented.	Four of five staff files randomly selected for review were missing evidence of reference checking.	Ensure evidence of reference checking is maintained in each staff file. 90 days
Criterion 1.3.5.2 Service	PA Moderate	The interRAI assessment process informs the development of the resident's	(i) There were no documented falls prevention strategies for the LTS-CHC resident assessed at high risk of falls. The same resident had been seen by the GP for swollen legs and pitting oedema, however there were no	Ensure care plans document

<p>delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>care plan; however only one of five care plans reviewed documented all the interventions and support required to meet the residents' needs. Short-term care plans are used to document and guide staff in the care of residents with short-term needs.</p>	<p>documented interventions in place; (ii) there was no pain management plan in place for a new pain requiring GP assessment and analgesia. The same resident was prone to urinary tract infections, however this was not identified in the care plan or signs/symptoms to report, (iii) one resident at medium risk of falls and potential for wandering did not have documented interventions included in the care plan for falls prevention and risk of wandering; and (iv) there was no behaviour management plan in place for resident (tracer) with verbal aggression.</p>	<p>the interventions and level of support required to meet residents' assessed needs.</p> <p>60 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.