

# Scovan Healthcare Limited - Taurima Rest Home

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## 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:** Scovan Healthcare Limited

**Premises audited:** Taurima Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 14 January 2020 End date: 14 January 2020

**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:** 28

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Taurima Rest Home provides rest home level care for up to 30 residents. On the day of the audit there were 28 residents living 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 is a registered nurse. She is appropriately qualified and experienced and is supported by a second registered nurse. Residents and family interviewed were complimentary of the services they receive.

There is one area of continuous improvement awarded around enhancing communication for the hearing impaired.

This certification audit identified that one improvement is required around their quality system.

## 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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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.

Māori values and beliefs are understood and respected. 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.		Some standards applicable to this service partially attained and of low risk.
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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.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. There are adequate numbers of staff on duty to ensure residents are safe. When not on site, an RN is on call. 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.		All standards applicable to this service fully attained with some standards exceeded.
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Service information is available to potential residents and their families. The registered nurse takes responsibility for managing entry to the service. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurse completes care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents and relatives interviewed confirmed that they were involved in care planning and care review processes.

An activity officer coordinates a weekly group activities programme that is varied and interesting and meets the abilities and preferences of the residents.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. The service has implemented an electronic medication system.

Meals are prepared on site. The menu reflects resident preferences and has been reviewed by a dietitian. Individual dislikes and dietary needs are accommodated.

## Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building has a current warrant of fitness and emergency evacuation plan. All rooms have hand basins and are personalised. The environment is 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 activities. The dining room and lounge seating placement encourages social interactions. 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 maintains a tidy and clean environment. Systems and supplies are in place for essential, emergency and security services. 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.

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. No restraint or enablers 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.

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 (registered nurse) 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. There have been no outbreaks.

## 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	1	43	0	1	0	0	0
Criteria	1	91	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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (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 and seven staff interviewed (one staff RN, two caregivers, one activities officer, one maintenance, one cook, one cleaner) could describe the Code and give examples of how it is incorporated into their job role and responsibilities. Staff receive training on the Code during their induction to the service. This training continues annually through the staff education programme.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Six residents' files reviewed contained signed general consent forms including for photographs, release of information, outings and names on birthday list. A separate consent form is signed for the facility website and Facebook page. 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 appropriately activated by the GP as required. Advance directive where completed were available on the resident file.  Admission agreements sighted align with the DHB contract requirements and have been signed within

		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 Commissioner (HDC) 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 although has not been needed. Staff receive 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 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, as evidenced through interviews and observations.</p> <p>Community links are established with a wide range of organisations (eg, Age Concern, Alzheimers New Zealand, local library and local churches). Residents regularly visit nearby cafes and shops and can take a taxi to town. Other rest homes visit the facility and vice versa. Church services are available on site.</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>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at reception.</p> <p>A record of complaints received is maintained by the facility manager using a complaint register. One consumer complaint was received in 2018 and three in 2019. No complaints have been received for 2020 (year-to-date). Documentation evidenced that complaints received were managed in accordance with HDC guidelines. Timeframes for responding to each complaint were met and all three complaints reviewed for 2019 were documented as resolved.</p> <p>Discussions with residents and families confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they may have had were addressed promptly. Complaints received were not being addressed in staff meetings (link 1.2.3.6).</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The RN discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly</p>

Consumers are informed of their rights.		resident meetings. All eight residents and three family interviewed reported that the residents' rights were being upheld by the service.
<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. Privacy signage is in place on communal toilet and shower doors. There is one double room that was being occupied by one resident.</p> <p>The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given 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, which begins during their induction to the service.</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 two residents who identified as Māori at the time of the audit.</p> <p>Each Māori resident has a Māori care plan completed that is linked to te whare tapa whā (sighted). Kaumātua and kuia are accessed through Tui Ora Health and through Taranaki Base Hospital. A kaumātua who has a family member living at the facility visits the facility regularly. This resident was interviewed, and their file was reviewed. The resident confirmed that their values and beliefs were upheld by the service. He is learning te reo Māori and shared his whakapapa with the auditor during the interview. The second Māori resident was unable to be interviewed but was observed listening to music in te reo Māori.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as a regular education topic. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service.</p>
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		the resident care plan, evidenced in all six care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which includes the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are 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, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>A registered nurse is available either on site (Monday – Friday) or on call 24 hours a day, seven days a week. Residents are reviewed by a general practitioner (GP) every three months at a minimum. All resident rooms are of a good standard.</p> <p>Resident meetings are held monthly. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed residents experience high levels of satisfaction with the services received.</p> <p>The service receives support from the district health board (DHB) which includes (but is not limited to) specialists visits (geriatrician, hospice, mental health services, dental care, dietitian). Physiotherapy services are provided as needed. A van is available for regular outings.</p> <p>The environment allows for close relationships between the staff and residents. Taurima prides itself on its family atmosphere. They make every effort to ensure that the residents and staff know that Taurima is a safe place to live/work where they are amongst friends. Care staff know the residents personally and treat them as individuals, with dignity and respect as observed during the audit. Care is individualised and holistic to meet the needs of the residents.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>The open disclosure policy 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 provide 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. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event. A communication sheet, held in the</p>

		<p>front of the resident's file, also documents the type of adverse events families wish to be informed about.</p> <p>An interpreter service is available and accessible if required, through the district health board. Families and staff are utilised in the first instance. There was one resident who spoke English but was gradually reverting to their native language. Family assist with interpreter services as required.</p> <p>A hearing specialist visits the facility once every three months to test and clean the residents' hearing aids. A recent quality initiative has addressed residents who are hearing impaired. This has resulted in a rating of continuous improvement (link 1.3.7.1).</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>Taurima Rest Home provides care for up to 30 residents at rest home level of care. At the time of the audit, there were 28 residents. Two residents were private boarders and the remaining 26 residents were on the age-related residential care services (ARCC) contract.</p> <p>Taurima Rest Home is owned by a couple who live in New Plymouth. They also own two other care facilities. The owners meet with the facility manager every two-three months (meeting minutes sighted). A 2017-2019 business plan includes goals, objectives and actions. Goals are regularly reviewed by the owners and facility manager. Work is currently underway on the development of an updated business plan for 2020. A draft is currently in place with plans to finalise the plan later in January.</p> <p>The facility is managed by a facility manager who is a registered nurse with a current practising certificate. She has worked in aged care for many years and will have been in her current role for two years in April 2020. She is assisted by a part-time registered nurse who has worked at this facility for over 20 years and is on site three days a week. The staff RN shares the on-call RN roster with the facility manager.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing 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</p>	FA	<p>The staff RN is responsible in the absence of the facility manager.</p>

the provision of timely, appropriate, and safe services to consumers.		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management system is established, which is understood by the facility manager and staff. Policies and procedures align with current accepted practice. Policies are reviewed two-yearly unless changes occur more frequently. A document review schedule is in place. New policies and updates to existing policies are discussed in staff meetings.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, and health and safety reporting. Missing was evidence of infection control data analysis and keeping staff informed regarding trends in infections. Staff were also not informed of complaints received and corrective action taken (if any) as evidenced in the staff meeting minutes.</p> <p>Data collected for a range of adverse events (eg, skin tears, bruising, falls, medication errors and challenging behaviours) is collated and analysed. A significant amount of work has been undertaken to reduce the number of resident falls. An internal audit programme is being implemented. Internal audit results and adverse event trends are discussed with staff as evidenced during interviews with staff and in staff meeting minutes. Where improvements are identified, corrective actions are documented and signed off by the facility manager when actioned.</p> <p>Resident satisfaction surveys are completed annually with the last survey completed in September 2019. Twenty-six surveys were handed out and eighteen were returned. The overall majority of responses indicated that residents were either satisfied or very satisfied with the service received. This was also confirmed during interviews with residents and families. Results were shared with staff, evidenced in the September meeting minutes. Corrective actions were implemented where a resident expressed a concern. No trends were identified.</p> <p>An interview was conducted with the health and safety officer who is the facility manager. Staff receive health and safety training, which begins during their induction to the service. Health and safety is a regular topic covered in the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Contractors are inducted into the health and safety programme, confirmed when reviewing completed contractor health and safety checklists.</p> <p>Falls management strategies include sensor mats, intentional rounding, and reviewing residents at risk of falling in staff meetings. A falls clock has been initiated and is posted in the staff room to identify times when residents are at a greater risk of falling. A specific falls management plan is developed for each resident who is identified as a high risk of falling.</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>The incident reporting policy includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action documented 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 (thirteen falls, one skin tear, one health and safety event). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurologic observations are documented for any suspected head injury. The facility manager signs off each event.</p> <p>The facility manager is aware of her responsibility to notify relevant authorities in relation to essential notifications with two examples provided (one wandering resident, one pressure injury).</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. Five staff files reviewed (one RN, one cook, two caregivers, one activities officer) included evidence of the recruitment process, signed employment contracts, reference checking and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.</p> <p>A register of current practising certificates for health professionals is maintained.</p> <p>There is an annual education schedule that is being implemented. Staff meetings precede in-services with high numbers of staff attending. Staff who are unable to attend are provided with meeting minutes and comprehensive notes from the in-service. They are required to sign that they have read this information.</p> <p>There are 12 caregivers employed. Two caregivers have achieved their level four Careerforce qualification, five have achieved their level three qualification and one caregiver has begun her level two Careerforce training. Both RNs have completed their interRAI training. Staff who administer medications have completed annual medication competencies and the RNs complete annual syringe driver competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>The staffing policy aligns with contractual requirements. A minimum of one RN is on site Monday – Friday during the day. The facility manager is responsible for clinical operations two days a week and the staff RN works the remaining three days a week. Both RNs share on-call responsibilities. An RN is available on-call 24 hours a day, seven days a week.</p>

suitably qualified/skilled and/or experienced service providers.		<p>There are adequate numbers of caregivers available with a minimum of two caregivers rostered during each shift. One long and one short shift (till 1400) cover the AM shift. One long and one short shift (till 2100) cover the PM shift and two caregivers cover the night shift. Caregivers are expected to do the laundry with separate cleaning staff.</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with residents and families confirmed staffing levels were 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 with information held in four separate folders. Entries are legible, dated, timed and signed by the relevant caregiver or RN, including their 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 been identified.</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. The manager/registered nurse 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 manager. Enquiry forms are completed for all potential residents or respite care.</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>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. 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. One resident file was reviewed who had required transfer to the public hospital. The file evidenced that family were informed, and that all transfer documentation was completed as per policy and sent with the resident on transfer to hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies and medication education. Medications (blister packs) are checked on</p>

safe and timely manner that complies with current legislative requirements and safe practice guidelines.		<p>delivery against the electronic medication chart and signed in by the RN. All medications are stored safely. The medication cupboard is being monitored for air temperature. All medications were prescribed for a resident. There were no self-medicating residents on the day of audit. The medication fridge monitoring is weekly, and temperatures were within the acceptable limits. Eye drops in the medication trolley had been dated on opening. A caregiver administering medications was observed to be compliant with medication administration policy and procedure.</p> <p>Twelve medication charts on the electronic medication system (implemented May 2019) were reviewed. The medication charts met prescribing legislative requirements. 'As required' medications had indications for use. Medication charts had photo identification and allergy status documented. The GP reviews the medication charts at least three monthly.</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>All meals and home baking are prepared and cooked on site by two cooks working a four day on, four day off roster. They are supported by an afternoon kitchenhand. The cook prepares and cooks meals as per the menu plan last reviewed by a dietitian September 2018. Resident preferences are reflected in the menu. The main meal is at midday. The cook receives a resident dietary profile and any dislikes or food allergies are accommodated. The cook is notified of any resident dietary requirements. Diabetic desserts and soft diets are provided.</p> <p>The food control plan has been verified and expires November 2020. The food control plan from is completed daily and includes fridge, freezer and chiller temperatures. End-cooked meat temperatures are taken and recorded. The kitchen is adjacent to the dining room where meals are served from the servery. Serving temperatures are recorded. All food services staff have completed food safety and hygiene training. All perishable foods and dry goods were date labelled. The dishwasher is checked regularly by the chemical provider. Chemicals were stored safely. A cleaning schedule is maintained.</p> <p>The service has been active in improving the quality of meals and resident satisfaction due to food dissatisfaction identified in a 2018 survey, resident meetings and food complaints. Food discussion was added to the monthly resident meeting agenda. Feedback resulted in resident preferences being included in the menu plan which was then reviewed by the dietitian. Further education was provided for kitchen staff. The midday meal was observed, and several residents interviewed stated the meals have improved. The cook (interviewed) interacts with residents at mealtimes and receives feedback on the meals.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	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

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.		required.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files reviewed demonstrated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Medical notes and discharge summaries were available. Files reviewed contained appropriate assessment tools that were completed such as Waterlow (pressure injury risk), Coombes (falls risk) and pain assessments. Assessment tools were reviewed as part of the six monthly interRAI assessment or earlier if there were changes to health. Care plans sampled were developed based on these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Six residents' long-term care plans reviewed were resident-focused and individualised. Care plans documented the required supports/needs, goals and interventions to reflect the resident's current health status in all resident files reviewed. A quick care guide provides a current summary of resident needs/supports for care staff and is updated following changes made to the long-term care plan. Relatives interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative involvement in the development of care plans with a signature on the front page of the care plan. Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. There was evidence of allied health care professionals involved in the care of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is documented evidence on the family communication form that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, GP visits, care plan reviews and changes in medications. Family members interviewed confirmed their relative's needs were being met.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan/evaluations were in place for two residents with chronic wounds. The chronic wounds were linked to the long-term care plans. There were no pressure injuries on the day of audit. The district nurses, and ulcer clinic had been involved in the care of the chronic wounds (leg ulcers). The service has access to the DHB wound nurse specialist as required.</p> <p>Continence products are available. The residents' files include a urinary continence assessment,</p>

		<p>bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, challenging behaviours, food and fluid intake, skin assessment checks, sleep monitoring, resident checks and neurological observations.</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>	CI	<p>The service employs an activity officer for 25 hours per week (1000 to 1500) Monday to Friday, to coordinate and implement the activity programme. The activity officer attends the two monthly regional diversional support group. The programme is planned in advance with the weekly programme being displayed. The activity officer makes daily contact with residents and reminds them of upcoming activities. Activities reflect resident preferences including newspaper reading/current affairs, "move it" exercises, word games, art, bowls, happy hours and movies. There are two volunteers who assist with activities and outings. Individual resident abilities to participate are assessed on admission and accommodated. One-on-one time is spent with residents with dementia, looking through picture books, photos, garden walks, reminiscing and involving the resident in meaningful activities such as household tasks. The service has introduced a sound system for the hard of hearing residents which has increased their participation in activities.</p> <p>The residents enjoy inter-home visits for bowls competition's and quizzes. The service has a van and there are regular outings (men's and ladies) to places of interest, including a drive through the park to see the Christmas lights. There are fortnightly outings to Age Concern lunches and concerts. Church services are held on site monthly. Events and festive occasions are celebrated.</p> <p>A "this is your life" profile is completed for each resident. The activity plan/social activity is included in the long-term care plan which is evaluated six monthly.</p> <p>The service receives feedback on activities at the monthly resident meetings. Residents interviewed were satisfied with the activities and enjoy the outings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly for residents who had been at the service six months. Written evaluations identified if the desired goals had been met or unmet. There was a written record of the resident/relative review meeting. Input is sought from caregivers, GP and the activity officer. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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>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 and the family communication form. The registered nurse provided an example of where a resident's condition had changed, and the resident was reassessed from respite care to rest home care.</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 sighted were labelled correctly and were all stored in locked rooms/cupboards safely throughout the facility. Safety datasheets are available. 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>	FA	<p>The facility has a current building warrant of fitness that expires September 2020. There is a basement used for storage which is not accessible to residents. A maintenance person is employed three hours a day for four days of the week to carry out maintenance and repairs and maintain gardens and grounds. Staff report repairs and requests into a maintenance book that is checked daily and signed off when repairs are completed. There are weekly, monthly, three-monthly and six-monthly planned maintenance schedules in place. Planned maintenance includes checks on resident mobility aids, call bells, civil defence equipment and monthly and hot water temperatures. All water temperatures in resident areas are below 45 degrees Celsius. Testing and tagging of electrical equipment has been completed. The chair scales were due for calibration in December 2019; however, an email was sighted stating the contractor will complete a calibration on 29 January 2020. 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. Environmental improvements include painting of all hallways and a larger TV in the lounge. Resident rooms are refurbished as they become vacant. Larger numbers have been put on the rooms to assist residents to find their room. The grounds and gardens are well maintained and provide seating and shade. There are raised garden beds. Currently</p>

		<p>there are no residents who smoke.</p> <p>Caregivers interviewed stated they had sufficient equipment to carry out the cares for residents as outlined in the care plans. There are sensor mats, a standing hoist and sling 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>All resident rooms have handbasins. There are an adequate number communal toilet and showering facilities. Privacy locks are in place. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.</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>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. One larger room has been certified for a double room and is currently single occupancy. Residents are encouraged to personalise their bedrooms as observed 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 and large separate lounge for the residents. The main dining room is adjacent to the kitchen area. There is a second small lounge (open plan) with seating arranged to allow for one-on-one activities, small group activities or visitors to use. All areas including the outdoors 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 safe</p>	FA	<p>There is a designated cleaner from Monday to Friday. Caregivers complete the laundry of personal clothing and linen. The cleaning trolley is well equipped with colour coded cleaning equipment. All chemical bottles are labelled. Protective wear including plastic aprons, gloves and goggles were available in the sluice/laundry. On the day of audit, staff were observed wearing correct protective</p>

and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		clothing when carrying out their duties. The laundry has a clean/dirty flow. The chemical provider monitors the effectiveness of laundry processes. Residents interviewed expressed satisfaction with cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum) with the most recent drill taking place on 4 December 2019. The orientation programme and annual education and training programme include fire and security training with sufficient numbers attending this mandatory 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 civil defence 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 barbeque 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 staff. Residents interviewed reported that call bells were responded to in a timely manner.</p> <p>There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>The facility is kept locked from dusk to dawn. Security checks are conducted two hourly by staff from 2330 to 0530 to ensure the external doors/windows are closed and secure.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and all resident rooms are appropriately heated and ventilated. Residents are able to adjust the heating in their rooms. All rooms have external windows that open, allowing plenty of natural sunlight.
Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of	FA	The infection control (IC) programme is appropriate for the size and complexity of the service. The registered nurse is the IC coordinator with a job description that outlines the responsibility of the role. She is supported by the manager/RN. The monthly infection control report is discussed at the monthly staff meeting. The IC programme is set out annually with input from the manager and the general

infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		<p>manager/owner/RN.</p> <p>Visitors are asked not to visit if unwell. There are hand sanitisers appropriately placed throughout the facility. There are adequate supplies of personal protective clothing. Residents are offered the influenza vaccine. There have been no outbreaks.</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>	FA	<p>The infection control team of two RNs (manager and IC coordinator) oversee infection control across the service. The IC coordinator has completed a Careerforce unit in infection control (level 4) and attended wound care education. The facility also has access to an infection control nurse specialist at the DHB, public health, GPs and practice nurses.</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 are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies that are current and reflect the infection control standard SNZ HB 8134:2008, legislation and good practice. These are regularly reviewed by the manager/RN. The infection control policies link to other documentation and cross reference where appropriate.</p>
<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. The infection control coordinator or manager complete orientation with new staff including hand hygiene and standard precautions and ongoing as part of the annual training schedule.</p> <p>Resident education occurs as part of providing daily cares. Care plans include ways to assist staff in ensuring this occurs.</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>	FA	<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 on all areas of service 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 and reported at the monthly staff meeting, however there is no documented evidence of analysing the data for trends (upwards or downwards) (link 1.2.3.6). Individual resident infection control summaries are maintained and short-term care plans for infections were sighted.</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. No residents were using restraints or enablers. The facility manager is the designated restraint coordinator. She is knowledgeable regarding this role.</p> <p>Staff receive training around restraint minimisation and managing challenging behaviours.</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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Data is collected for a range of adverse events but was missing for infection control data. Staff are informed of audit results, satisfaction survey results and adverse event data, however meeting minutes do not reflect they are not kept informed regarding infection control statistics and complaints received.	(i). Data analyses is missing for infection control surveillance reporting (ii). Staff meeting minutes do not adequately reflect infection control surveillance data/analyses and complaints	(i). Ensure infection control data is analysed. (ii). Ensure staff are kept informed regarding infection control surveillance data/analyses and complaints received (if any).  90 days

## Specific results for criterion where a continuous improvement has been recorded

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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
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Residents who are hearing impaired have expressed higher levels of satisfaction since a microphone sound system was implemented.	It was observed by staff that the number of residents attending activities had declined. It was also observed that some residents were struggling to hear what was being said in residents' meetings and therefore tended to disengage. A survey was completed that indicated in 20 of 25 surveys returned that a selection of residents were struggling with their hearing. A raffle raised money for a new microphone sound system. This sound system is now being used during various group activities (eg, bingo, word games, residents' meetings). A post survey was conducted to measure the levels of satisfaction with the sound system. Fifteen of twenty-seven residents acknowledged that the new sound system was effective. It was also confirmed in an interview with the activities officer that residents are engaging more in activities and in residents' meetings which she attributes to this quality initiative.

End of the report.