

# Homestead Ilam Care & Hospital Limited - Homestead Ilam Care & Hospital

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	Homestead Ilam Care & Hospital Limited
<b>Premises audited:</b>	Homestead Ilam Care & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 27 October 2020      End date: 28 October 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	36



# 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.

## General overview of the audit

Homestead Ilam provides rest home and hospital level care for up to 39 residents. On the day of the audit there were 36 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional 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, relatives, general practitioner, staff and management.

The facility is being managed by the (non-clinical) owner who has owned the facility since 2017. The owner is supported by a clinical manager who is an experienced aged care registered nurse. A quality coordinator, also a registered nurse, is employed to support the management team. Residents, a relative, and the GP interviewed were complimentary of the service provided.

The prospective purchaser has a background in executive management, investments and banking. The prospective purchaser reported the current policies, systems and staff will remain in place following the purchase. The current owner will continue to provide support to the new owners for the initial four weeks post the takeover and as required.

The following areas for improvement were identified at this provisional audit; first aid training, documentation timeframes, and environmental issues.

## **Consumer rights**

Homestead Ilam provides care in a way that focuses on the individual resident. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. Information about services provided is readily available to residents and families/whānau. Cultural and spiritual assessment is undertaken on admission and during the review processes. 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. Residents are encouraged to maintain former links with the community. There are a number of community visitors to the home in accordance with Covid-19 regulations.

## **Organisational management**

Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. The annual quality and risk management plan and quality and risk policies describe Homestead Ilam's quality improvement processes. 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. The health and safety programme meets current legislative requirements. 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**

An admission package is provided to family and residents prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses are responsible for all aspects of care planning, assessment and evaluation of care with the resident and/or family input. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The diversional therapist provides and implements the activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Residents commented very positively on the meals provided.

## **Safe and appropriate environment**

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

## **Restraint minimisation and safe practice**

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint, should this be required. Staff receive regular education and training on restraint minimisation. No residents were using restraint, and five residents were using enablers on the day of the audit.

## **Infection prevention and control**

There is a suite of infection control policies and guidelines to support practice. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the infection control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks. A pandemic plan was actioned, and Covid-19 policies and procedures have been developed and implemented. Homestead Ilam continues to implement current Covid-19 regulations around contact tracing.

## 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)
<b>Standards</b>	0	42	0	1	2	0	0
<b>Criteria</b>	0	90	0	1	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>A policy relating to the Code is implemented. Leaflets on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) are accessible to residents and their families. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme. An education session the residents code of rights was held in September 2019.</p> <p>The manager and clinical staff interviewed (one clinical manager, one quality coordinator, two registered nurses (RNs), six caregivers, and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care.</p> <p>Interview with the prospective purchaser confirmed support would be provided by the current owner for the initial four weeks and as required following purchase, including implementation of the Code. The prospective owners have a good understanding of implementation of the code of resident rights.</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 consent.</p>	<p>FA</p>	<p>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advance directive instructions. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making (as able).</p>
<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>	<p>FA</p>	<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. 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. Residents and relatives interviewed were aware of the role of advocacy services and their right to access support.</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>	<p>FA</p>	<p>Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirmed the staff help them access community groups. Residents and staff interviewed confirmed open visiting. Residents informed that relatives and friends are encouraged to be involved with the service and care. Male residents are supported to attend the community Men's group. One resident is supported to attend a church group. Bunnings have invited residents to attend their workshops on gardening, carpentry, and do-it-yourself workshops which include afternoon tea.</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>	<p>FA</p>	<p>The manager and clinical nurse manager maintain a record of all complaints, both verbal and written. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p>

		<p>Four complaints have been logged since the previous surveillance audit in July 2019, (one in 2019, and three in 2020) year to date. There have been no complaints received since the surveillance audit on 1 October 2020. All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Complaints include that the complainant was satisfied with the outcome.</p> <p>Staff interviewed could describe the procedure for directing complaints to the most senior person on duty. Discussions with residents and the relative confirmed they were provided with information on complaints and complaints forms. Complaint forms are available in the foyer. The policy is visible on the noticeboards beside the nurses' station.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</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. The clinical manager or registered nurse discuss aspects of the Code with residents and their family on admission. Information on the code of rights and advocacy services are available in the foyer. Large print posters of the Code and advocacy information are displayed on noticeboards throughout the facility. Discussions relating to the Code are also held during the resident meetings. Six residents (four rest home and two hospital) and one relative (rest home) interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' rooms are personalised and decorated to the residents' individual taste with their belongings. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Caregivers confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and relatives interviewed, and observations during the audit, confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, last held in May 2019. The staff interviewed could fluently describe examples of</p>

		abuse and signs and symptoms residents may portray.
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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	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. The caregivers interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The staff interviewed were knowledgeable around Māori culture and practices. Linkages with Māori community groups are available and accessed as required. On the days of the audit, there was one Māori resident who chose not to have affiliations with their culture.
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents' interviewed confirmed that their values and beliefs are considered, and that staff take into account their cultural values. The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. The care plans sampled included the residents' values, spiritual and cultural beliefs. On the days of the audit there were residents from Pacific Island cultures. Their individualised cultural preferences, values and beliefs were documented in the care plans. An education session around culture is planned for November 2020.
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions, and reconfirmed through education and training sessions, staff meetings and performance management. The staff employment process includes the signing of house rules and a service code of conduct. Interviews with the caregivers confirmed their understanding of the boundaries of the caregivers' role and responsibilities.
<p><b>Standard 1.1.8: Good Practice</b></p>	FA	The documented quality programme monitors contractual and

<p>Consumers receive services of an appropriate standard.</p>		<p>standards compliance and the quality of service delivery in the facility. Policies and procedures have been reviewed two yearly. These are available in hard copy. A variety of staff meetings and residents' meetings have been conducted. Residents and the relative interviewed spoke very positively about the care and support provided.</p> <p>There is an active culture of ongoing staff development with the Careerforce programme being implemented. There are implemented competencies for caregivers and registered nurses. The service has implemented an electronic medication system, which has reduced medication errors, there is ongoing competencies and education around medication management. The service have implemented a 'buddy' system for caregivers, so they have dedicated partners for residents who require two person assists with transfers, and personal cares, this is in response to reducing the number of bruising reported through incident reports. A physiotherapist is available for four hours per week, and a podiatrist visits regularly. Members of the specialist multidisciplinary team have input into resident care when required. The wound care specialists have had input with a resident with a resolving pressure injury.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Residents and relatives interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The manager and clinical manager (RN) operate an open-door policy. Fifteen incident/accident forms reviewed from October 2020 identified the next of kin (NOK) were notified following a resident incident. The clinical manager, the registered nurses and caregivers confirmed relatives are kept informed. The relative interviewed confirmed they are notified promptly of any incidents/accidents. Interpreter services are available as required.</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>	<p>FA</p>	<p>Homestead Ilam provides care for up to 39 rest home and hospital level residents. Thirty-seven of thirty-nine beds are dual-purpose (two beds are rest home only). One room has been certified as a double room (A5), the manager reported this has only ever been used as a single</p>

	<p>room.</p> <p>On the days of audit there were 36 residents.</p> <p>On the day of the audit, there were two younger residents on a long term support - chronic health contract (LTS-CHC) at rest home level, and 13 residents at rest home level care on the age-related residential care contract (ARRC). There were 19 residents receiving hospital level care (ARRC) including one resident on an individual funding Ministry of Health contract. There were four residents on respite care.</p> <p>The 2019-2021 business plan has been documented and reviewed annually (last completed in April 2020). The 2020 quality plan has been implemented. Quality goals for the year include the commencement of a day programme, increasing staff education, to remain client focused, and general refurbishments. Due to Covid-19, the day care programme has been put in hold. Quality goals feature an agenda item for the quality meeting and progress is documented in the meeting minutes.</p> <p>The facility is managed by a (non-clinical) owner. She is supported by a full-time clinical nurse manager who has been employed in the role for almost two years. The clinical manager was a registered nurse at the facility for ten years prior to moving into the clinical manager role. The quality coordinator, a registered nurse, also worked at the facility as a registered nurse for eight years prior to becoming the quality coordinator three years ago. The quality coordinator currently works three days a week.</p> <p>Both the manager and the clinical nurse manager have attended at least eight hours education around the management of an aged care facility.</p> <p>The prospective purchaser has a background in investment banking and has retail management and project management experience. The prospective purchaser acknowledged they have no experience managing an aged care facility, as this is the first time, they have developed a transition plan for the aged care sector. They have support from experienced mentors in the aged care sector, who will provide education and support, and provide oversight in the early transition period as required. The prospective purchasers have previous experience in managing staff, establishing and following</p>
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		<p>health and safety guidelines.</p> <p>The prospective purchasers have developed a transition plan in consultation with the current owners that will allow for a seamless transition for residents and staff. The existing mission statement and philosophy will be adopted by the prospective purchaser. The prospective purchaser (interviewed) anticipates minimal disruption and instability during the four-week transition process. The prospective purchaser plans to manage the facility. The current owner/manager will continue to be available for advice as required during the first two months.</p> <p>The prospective purchasers have registered with the Ministry of Health and await log-in details. They plan to make contact with the Christchurch District Health Board (CDHB). The prospective purchasers have an understanding of the different certified service types at the facility.</p> <p>The prospective purchaser plans to undertake appropriate management education including health and safety. Relevant authorities have been notified of the pending change of ownership. The prospective owners have been in contact with the portfolio manager for the DHB. The tentative date of sale is 18 January 2021.</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>	<p>FA</p>	<p>The clinical manager along with the quality coordinator, provide cover during a temporary absence of the manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service's policies are reviewed by an external contractor every two years, or sooner if required. Staff have access to policy manuals. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data is collected and entered onto the electronic system, analysed and presented at the meetings by the quality coordinator. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated.</p>

		<p>The combined quality/health and safety/infection control meetings are held two-monthly. The quality team is representative of the facility. Meeting minutes evidenced quality data, trends and analysis including areas for improvement around infections, accidents and incidents, health and safety, restraints/enablers, concerns/complaints, internal audit outcomes and quality goals. Agenda items cover health and safety issues, new hazards, hazard register reviews, education and concerns/issues from each department of the facility. Results of this meeting are discussed at the monthly staff meetings. The minutes of the staff meetings evidenced discussion around quality data and corrective actions.</p> <p>The satisfaction survey completed in March 2019 evidenced overall satisfaction with the service. Corrective actions were identified for areas of low satisfaction and were discussed at the combined quality meeting and staff meetings. The food satisfaction survey for 2019 showed overall satisfaction with the meals, and residents provided suggestions around the types and variety of meals which have been incorporated into the menu. The 2020 food satisfaction survey has been distributed, and responses have yet to be collated. The 2020 resident satisfaction survey has been distributed and results were still being received at the time of the provisional audit.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</p> <p>Interview with the prospective purchasers confirmed the current quality management system and performance monitoring programme will continue following the sale. The clinical manager and quality coordinator will mentor the new owners to the quality risk system, the current owner/manager will be available for advice as required. There will be no changes to policies and the prospective purchaser plans to continue to engage the aged care consultant for the review and update of policies. The prospective owners will include health and safety training as part of their education schedule within the first six months of ownership.</p>
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<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>	<p>FA</p>	<p>Individual paper-based reports are completed for each incident/accident by the caregivers and registered nurses (first on the scene), with immediate action noted and any follow-up action(s) required. The incident reports are reviewed and signed off by the quality coordinator (RN) and entered onto the electronic system. The data is analysed, and corrective actions to minimise risks are discussed at meetings.</p> <p>Fifteen electronic resident related accident/incident forms were reviewed (eight hospital and seven rest home level). Each event involving a resident reflected follow-up by a registered nurse. The next of kin had been informed (as requested by relatives). Neurological observations are conducted for suspected head injuries, and where possible opportunities to minimise future risks were identified and implemented.</p> <p>The management team are aware of their requirement to notify relevant authorities in relation to essential notifications. Three section 31 notifications were made in 2019 and five in 2020 for residents leaving the facility without staff knowing. A Section 31 notification and incident report was sighted for the resident with a current pressure injury. This is an improvement since the previous audit on 1 October 2020. There have been no outbreaks since the previous surveillance audit in July 2019.</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>	<p>PA Moderate</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>Seven staff files reviewed (two RNs, two caregivers, one laundry assistant, one cook and one diversional therapist) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. Two of the staff were recently employed in 2020, and one appraisal was due in September (not yet completed). The sample was extended to look at a further three files only around appraisals, and all were up to date. The</p>

		<p>previous finding has been addressed.</p> <p>A register of practising certificates was sighted. A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: medications, restraint, infection control and hand washing, hoists and manual handling).</p> <p>There is an annual education and training schedule being implemented. The caregivers are encouraged to undertake a New Zealand Qualification Authority (NZQA) qualification (Careerforce). Currently, all 18 caregivers have qualifications, 11 caregivers with level 4 NZQA, four with level 3 and three with level 2.</p> <p>Registered nurses are provided opportunities for training from the DHB and attend external first aid and syringe driver training, however not all first aid certificates were current.</p> <p>The clinical nurse manager and registered nurses are able to attend external training such as seminars and education sessions with the local DHB. Two of the current five RNs, and the quality coordinator are trained in interRAI. Two RNs have enrolled to attend the course when next available. One RN is currently completing the training.</p>
<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>	<p>FA</p>	<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. There were three registered nurses resign this year, however, the manager and clinical nurse manager reported they now have a full complement of registered nurses, with the most recently employed registered nurse due to commence orientation at the beginning of October 2020. Agency staff have been utilised to cover vacant RN shifts, however due to leave/sickness, the clinical nurse manager was covering the weekend night shifts on occasions. The management reported all staff members will return to their regular positions once the new RN is orientated to the position.</p> <p>The manager, and clinical manager are full-time Monday to Friday.</p>

	<p>The quality coordinator (RN) works 8 am to 4.15 pm Monday, Wednesday and Thursday. There is one registered nurse on each shift.</p> <p>Kyle (hospital) has 14 beds with 12 hospital level residents.</p> <p>Morning shift has four caregivers: 1x 7 am to 3.15 pm, 2x 7 am to 1.30 pm and 1x 7 am to 2 pm (senior caregiver with medication competency).</p> <p>Afternoon shift has two caregivers: 1x 3 pm to 11 pm, and 1x 4.30 pm to 11 pm.</p> <p>Ilam (rest home) has 14 beds, with 13 rest home residents including three respite residents and one hospital level resident. Residents are very independent in this unit.</p> <p>Morning shift has two caregivers: 1x 7 am to 3.15 pm Tuesday, Wednesday, Friday and the weekends. Monday and Thursday 7 am to 1.30 pm.</p> <p>Afternoon shift has one caregiver from 4 pm to 8 pm. The caregivers from Kyle and Homestead cover Ilam from around lunchtime till 4 pm, and then from 8 pm to 11 pm.</p> <p>Homestead (rest home/ hospital) has 11 beds with seven hospital level residents and four rest home level residents including one respite resident.</p> <p>Morning shift has two caregivers: 1x 7 am to 3.15 pm, and 1x 7 am to 1.30 pm.</p> <p>Afternoon shift has two caregivers: 1x 3 pm to 8.30 pm, and 1x 4 pm to 8 pm. The caregivers from Kyle cover from 8.30 pm to 11 pm.</p> <p>Night shift has one registered nurse and one caregiver from 10.45 pm to 7 am across the facility.</p> <p>Residents, relatives and staff interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares. Agency staff have been used if there is no staff available to cover shifts. Staff interviewed reported this is rarely required, and all vacant shifts were covered as evidenced on the rosters sighted.</p>
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		During interview, the prospective owner stated there will be no changes to the current staffing levels or rostering.
<p><b>Standard 1.2.9: Consumer Information Management Systems</b> Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	The resident files were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files were located in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member.
<p><b>Standard 1.3.1: Entry To Services</b> Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	The manager screens all potential residents prior to entry and records all admission enquires. The service has comprehensive 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 and the relative interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical manager. Six signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements.
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b> Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service. The yellow envelope system is used for transfers to hospital.
<p><b>Standard 1.3.12: Medicine Management</b> Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	FA	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

<p>guidelines.</p>		<p>competencies and education on medication is provided. The medication storage area is secure. Medications (robotic rolls) are checked on delivery by the RN against the electronic medication chart and verified on the medication system. Any discrepancies are fed back to the pharmacy. Standing orders are not used. All eyedrops were dated on opening.</p> <p>Twelve medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three-monthly. 'As required' medications had indications for use and administered as prescribed. The effectiveness of as required medications was documented in the electronic medication system. The medication fridge is monitored each night. The medication room temperature is checked and recorded daily and remains between 22 and 23 degrees Celsius for the month of October 2020. This has been implemented since the surveillance audit on 1 October 2020. The previous self-medicating resident is no longer self-medicating medications and has a medical review on file.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at the service are prepared and cooked on site. The cook is supported by a second cook and two tea cooks, morning and afternoon kitchenhands. The cook interviewed was knowledgeable of the preferences of the residents. They reported the residents often provide feedback on the meals provided when leaving the dining room. The five-weekly seasonal menu has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to residents in the dining room. Staff were observed delivering meals and assisting residents with their lunchtime meals as required. The cook receives dietary profiles for each resident and notified of any dietary changes. The service provides pureed/soft, dairy free and diabetic desserts. Food allergies, dislikes, cultural and religious preferences are accommodated.</p> <p>Kitchen staff are trained in safe food handling, and food safety procedures were adhered to. The food control plan expires in July 2021. Fridge, freezer, chiller and end-cooked temperatures are taken</p>

		<p>and recorded daily. All foods were date labelled.</p> <p>Resident weekly meetings and surveys allowed the opportunity for resident feedback on the meals and food services generally. Interviews with residents and a family member indicated satisfaction with the food service.</p> <p>The kitchen has been fully refurbished to include the floors, walls and ceilings. The cabinetry, oven and dishwasher have been renewed. The pantry/storage area and cool room was redecorated with new shelving/storage. The fridges and chiller have been replaced.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Potential residents would only be declined if there were no beds available or if they could not meet the service requirements. The manager stated that declined referrals would be communicated to the potential resident/family and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>An RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly. The interRAI assessment is completed in files reviewed (link 1.3.3.3). The outcomes of assessments form the basis of the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans reviewed were resident-centred and documented the required support needs in sufficient detail. The obsolete interventions had been crossed out and new interventions added. Residents with challenging behaviours had triggers (where they could be identified), a description of behaviour, and individualised de-escalation techniques documented. Long-term care plans reviewed had all been fully completed, and activities assessments and plans were in place for all resident files reviewed. This is an improvement since the previous surveillance audit 1 October 2020.</p> <p>Care plans reviewed demonstrated service integration and input from allied health. InterRAI assessments have not always informed the care</p>

		<p>plans in a timely manner (link 1.3.3.3). There was evidence of service integration with documented input from a range of specialist care professionals, including, Nurse Maude specialists, mental health services for older people, physiotherapy and podiatry support and advice was evidenced and documented. Assessments and care plans reviewed included input from allied health professionals. The relative interviewed confirmed care delivery and support by staff is consistent with their expectations. Caregivers interviewed reported they found the care plans easy to follow and contain information to provide quality care for residents. Changes identified by caregivers are added to the care plan interventions as confirmed during interviews.</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>Registered nurses and caregivers follow the care plan and report progress at each shift handover. If external allied health requests or referrals are required, the clinical nurse manager initiates the referral (eg, wound care specialist, dietitian, or mental health team). The relative interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents. Short-term care plans are utilised to document short-term needs for resident changes to health. These had been reviewed in a timely manner or added to the long-term care plan.</p> <p>Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies (sighted). Specialist wound, and continence advice is available by referral.</p> <p>There were eight wounds including three pressure injuries; one stage three which had a corresponding section 31 notification made, and an incident report completed. Two stage 2 pressure injuries had corresponding incident reports completed. Current wounds included two skin tears, one scratch, one ulcer, and one abrasion. Each wound had an individual wound assessment, wound plans and evaluation forms in place. Short-term care plans for acute wound care had interventions around management of wounds and dressings. This is an improvement since the previous audit on 1 October 2020.</p> <p>All residents with pressure injuries had appropriate prevention and</p>

		<p>management documented and provided, including pressure relieving equipment, and monitoring charts completed as instructed in the care plan. Access to specialist advice and support is available as needed. Care plans document allied health input. Residents with previous unintentional weight loss have been discussed with the GP. Supplements were prescribed, and residents were now maintaining or gaining weight. No residents reviewed met the criteria for referral to the dietitian.</p> <p>There was evidence of turning charts, monthly (or more frequent) weight and vital sign monitoring, food and fluid charts and behaviour charts in place.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT), who is currently studying business management as well as running the activity programme at Homestead Ilam. The programme runs from Tuesday to Saturday when the DT is on course, and otherwise Monday to Friday. On admission, the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>The diversional therapist is proactive in providing meaningful and enjoyable experiences for all residents at Homestead Ilam. Activities included outings as well as community involvement. Interactions with the residents start around 9.15 am, when residents are setting up the menu board, and sharing the newspaper prior to the newspaper reading. One-on-one time is spent with residents prior to the start of the programme at 11 am. Morning activities usually comprise of a group activity such as exercises, or a group game. Bible study is well attended weekly. Afternoon activities include baking, walking group, indoor sports, music hours.</p> <p>There are volunteers involved in the programme, including an art therapist, who runs art classes, a music therapist for music therapy, which the DT reports is especially beneficial for residents with memory</p>

		<p>loss. Pet therapy is provided according to Covid-19 guidelines, and gardening is available for residents.</p> <p>One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Community visitors include preschool children, guest speakers and entertainers. Themes and events are celebrated.</p> <p>There are weekly outings for rest home and hospital level residents including library visits, inter-home visits and scenic drives.</p> <p>A debrief meeting is held weekly, to gain feedback over the week, and the residents provide suggestions for outings, and things they would like to do the following week.</p> <p>Younger residents are supported to maintain links with groups in the facility, with one resident being supported to attend the church group independently using public transport. Another resident is very active and enjoyed do it yourself (DIY) projects. This resident has a health and safety plan around assisting the maintenance person with DIY projects. Together they have designed, built and painted planters for the residents to plant with vegetables. Residents' interviews confirmed they enjoy the variety of activities and were very satisfied with the activities programme, as residents have a choice and are able to maintain previous interests and are encouraged to try new experiences. Residents have been invited to Bunnings to attend workshops on gardening, do it yourself projects and carpentry, an afternoon tea is provided. One resident is supported to work on their cross-stitch project.</p> <p>Through the Covid-19 lockdown period, zoom church services were held, bible studies were held as usual. Regular facetime and zoom sessions were held with families, and individual and group music therapy was held via zoom. Facebook (with consent) was utilised to keep relatives in touch with what residents were busy doing. Residents were able to bake and participate in exercises. Resident meetings were held by providing residents with the agenda, so they could put their suggestions and feedback on paper, which was collated and fed back to the residents.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Overall, the registered nurses evaluate initial care plans (link 1.3.3.3). Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status, however, evaluations did not always align with interRAI reassessments (link 1.3.3.3). 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 plan if the problem is ongoing, as sighted in resident files sampled. Residents (where appropriate) and the relative interviewed stated they were involved in care planning reviews or were informed of changes made.</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>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The GP and RN involve the resident (as appropriate) and relative in discussions around referrals and options for care. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</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>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemicals are stored in a locked cupboard. Chemical bottles sighted have correct manufacturer labels. A sluice tub is located within the laundry. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. All staff have completed chemical safety training in April 2019.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 1 June 2021. The maintenance man was interviewed and works 24 hours a week. He completes maintenance requests and repairs, planned maintenance and gardens and grounds. Staff complete yellow forms for requests for repairs. A record is maintained of all repairs which is signed off by the maintenance man. There is a 52-week</p>

		<p>planned maintenance schedule in place and all maintenance undertaken is logged by the quality coordinator. Planned maintenance includes interior and exterior building, equipment checks, electrical checks and two-weekly hot water temperature checks. Essential contractors are available 24 hours. There is ongoing refurbishment of resident rooms and communal areas and replacement of furnishings and equipment as needed. However, work is required to the pillars on the veranda and the kitchen window. The corridors have been painted throughout the facility by the current owner.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe ramp access to courtyards and garden areas. Outdoor areas have wrap-around established gardens. Seating and shade are provided.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs, chair scales, hoists and pressure injury resources (if required), to safely deliver the cares as outlined in the residents' care plans.</p> <p>The prospective purchaser has no immediate plans for making environmental changes to Homestead Ilam.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></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>	<p>FA</p>	<p>All resident rooms have toilet ensuite facilities. Six of the rooms in Homestead wing have full ensuite facilities. There are adequate numbers of shared showers in each wing for residents to use. The shared facilities have signs to indicate if the shower is being used. Privacy curtains are in place in the shower rooms and the resident ensuites. Residents confirmed staff respect their privacy while attending to their care, however, not all shower areas comply with health and safety and infection control standards (link 1.4.2.1).</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms currently have single occupancy. There is one certified double room (A5) in the Homestead wing. Thirty-seven of thirty-nine rooms are certified as dual purpose. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms. Rooms viewed</p>

		were personalised with residents own furnishings and adornments as viewed on the day of audit. Resident rooms have large windows with lovely views of the gardens.
<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 large communal lounge and dining area that is well used and several smaller areas including a library area. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The main lounge is used for activities. There is a specific area for the hairdresser in a shower room. The outdoor courtyards are also used for activities during the summer.</p> <p>The corridors have been painted throughout the facility. The carpets have been replaced in the Ilam and Homestead wings. There is a smoking area for residents outside of the building. The dining room has been redecorated which included new flooring, curtains, and the installation of a heat pump.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry assistant and a housekeeper were interviewed, both have had training around chemical safety and attend manual handling.</p> <p>Policies and procedures provide guidelines regarding the safe and efficient use of laundry and cleaning services. There is dedicated laundry and housekeeping staff.</p> <p>The laundry has a defined clean/dirty area. Linen and personal clothing is delivered to the laundry in covered buckets where it is sorted. The washing machine and dryer is serviced regularly. The laundry has been refurbished to include a new commercial washing machine, with a separate washing machine for delicates. There are two commercial dryers which were replaced during the refurbishment. The sluice machine has been replaced and is housed in the laundry. The cleaner's trolley is locked away when not in use. There is a dispensing system for the re-filling of chemical bottles. Safety data sheets are available. There is protective personal clothing available. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. Residents and relatives interviewed were satisfied with the laundry service and</p>

		cleanliness of the communal areas and their bedroom.
<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>	FA	<p>Emergency, disaster policies and procedures are documented for the service. Fire drills occur every six months (last fire drill occurred in March 2020). Education around fire and emergency responses was held in September 2020. The orientation programme and annual education/training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. First aid training is completed by registered nurses, however not all are current (link 1.2.7.5). A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food and water supplies to last for three days, and blankets are available for residents. A gas BBQ and gas hobs in the kitchen are available for alternate cooking, and a generator can be accessed. Emergency lighting is in place. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell alarms in close proximity.</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>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light. There is radiator heating in the corridors in Homestead wing, with ceiling heaters in the rest of the building and resident rooms. There is a heat pump in the dining room.</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, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager is the infection control coordinator and has a defined job description that outlines the role and responsibilities. The infection control team (quality team, representative of the facility) report bi-monthly at the combined quality/health and safety and infection control meeting. The IC programme is appropriate for the size and complexity of the service. Infection control is discussed at the daily handovers with staff to include ongoing and new infections and interventions and to alert staff to the short-term care plans. Graphs of</p>

		<p>statistics and the quality meeting minutes are available to staff in the 'memo' folder at the nurses' station.</p> <p>There are adequate hand sanitisers placed throughout the facility. Adequate stocks of personal protective equipment were sighted. Visitors are asked not to visit if they are unwell.</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 coordinator manages infection control with support from the quality coordinator. The infection control coordinator has attended external education in the last year. The infection control coordinator has access to infection control personnel within the district health board, infection control specialist, laboratory services and the GP.</p> <p>Covid-19: A resource folder was maintained with all current information and guidelines to follow for each level of lockdown. The quality coordinator has developed a file with specific instructions and signage to use for the stages of lockdown for staff to utilise in the event of changes in levels. All screening was adhered to, and records maintained. The service has been compliant with guidelines and documentation requirements throughout the period. All visitors are required to complete a wellness declaration and use the hand gel when signing into the facility. The residents and relative interviewed felt they were updated regularly and was complimentary of the way the management and staff dealt with the lockdown at different levels. All stocks of personal protective equipment and outbreak equipment required is held centrally in the facility.</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>Homestead Ilam has infection control policies and an electronic and hard copy infection control manual obtained through an external provider (HCSL), which reflect current practise and have been regularly reviewed. Policy, procedures and the pandemic plan have been updated to include Covid-19.</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>	<p>FA</p>	<p>All new staff receive infection control education at orientation, including hand washing and an infection control questionnaire. Infection control education is included in the annual education planner. Education was held around donning and doffing personal protective equipment, handwashing, and outbreak management in July 2020.</p> <p>There is an infection control folder and the Covid-19 chart in the nurse's station for quick reference for any infection control events.</p> <p>Resident education occurs as part of care delivery.</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>	<p>FA</p>	<p>Infection monitoring is the responsibility of the IC coordinator (the clinical manager). All infections are entered into the electronic database, which generates a monthly analysis of the data and includes benchmarking against other similar services. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly, three monthly and annual seasonal comparison of infection events. Outcomes are discussed at the combined quality/infection control/health and safety meetings, registered nurse, and daily handovers. The GPs also monitor and review the use of antibiotics. There has been a generally low incidence of infection in 2020.</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 minimisation and safe practice policy that is applicable to the service. The nurse manager and the clinical manager share the restraint coordinator position and have job descriptions in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually (last held in August 2019). Caregivers interviewed could fluently describe the differences between restraint and enablers and procedures around these.</p> <p>No residents were using restraint and five residents were using enablers (four residents using lap belts on wheelchairs and one resident using a lap belt and a bed rail). All residents had consent</p>

		<p>forms in place which has been signed by the resident and the GP. Assessments (including risks) and care plans were in place and reviewed three- monthly. Monitoring forms have been maintained as instructed in the care plans.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	The clinical manager and the DT have current certificates. Currently there are four registered nurses (three RNs and one quality coordinator) with expired first aid certificates. Three RNs have been enrolled onto a first aid course in November 2020.	Four registered nurses do not have current first aid certificates and therefore there is not staff member across 24/7 with a current first aid certificate.	<p>Ensure there is a staff member with a current first aid certificate across 24/7.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Moderate	Risk assessments are completed on admission including a clinical risk assessment (which identifies risks associated with medical history). Information from the assessments has been included in the care plans, however, not all interRAI assessments and reassessments have been completed within timeframes. Long-term care plans were overall reviewed at least six-monthly, however, did not always have an interRAI reassessment completed first. This is an ongoing shortfall.	<p>(i) InterRAI assessments and reassessments were not completed within timeframes for three long-term hospital files reviewed.</p> <p>(ii) One rest home resident and one hospital resident did not have initial care plans developed within three weeks of admission.</p>	<p>(i) and (iii) Ensure interRAI assessments and reassessments are completed within expected timeframes and correspond with care plan evaluations.</p> <p>(ii) Ensure all initial care plans are documented within three weeks of admission.</p>

		Progress notes are maintained and written at the end of each shift by caregivers. There was evidence of RN follow-up of concerns, however, if there had been no concerns or issues identified, progress notes were not routinely completed. The sample was increased by one (only reviewing RN progress note entries), the RN progress notes were completed weekly for rest home residents for the month of October 2020. A chart has been developed for RNs to sign when weekly reviews of rest home residents have been documented.	(iii) Long-term care plans had not been evaluated in line with interRAI assessments for two hospital and one rest home residents.	60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The building has a current warrant of fitness in place. A preventative and reactive maintenance schedule is in place. Two of the pillars on the veranda in the old part of the facility have currently got supports in place and another appears to be rotten. The current owner will discuss this with the lawyer and the prospective purchaser. The lower windowsill has become detached from the bottom of the kitchen window. The current owner plans to fix this. An internal audit around toilet and shower facilities identified some discolouration of vinyl and chipped tiles in shared bathroom facilities. Discussed with the current manager who will alert the maintenance.	(i) The pillars on the veranda currently require supports and another is rotten beside the door.  (ii) The windowsill has come away from the bottom of the kitchen window.  (iii) The shared shower in the Homestead wing has cracks in the vinyl wall where a handrail has been removed. There is silicone in the holes where screws have been to prevent water damage.  (iv) There were rust marks on the wall of the Ilam shared shower room.  (v) Tiles are chipped in the shared bathroom in the Kyle wing	(i) Ensure the pillars on the veranda are repaired.  (ii) Ensure the kitchen windowsill is fixed.  (iii) Ensure the cracked vinyl wall in the Homestead shared shower room meets health and safety and infection control standards.  (iv) Ensure the rust marks are cleaned.  (v) Ensure the chipped tiles meet infection control and health and safety requirements  180 days

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## 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, 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
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End of the report.