

Te Awa Care Limited - Te Awa Care

Introduction

This report records the results of a Surveillance 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:

Legal entity: Te Awa Care Limited

Premises audited: Te Awa Care

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 10 December 2020 End date: 11 December 2020

Proposed changes to current services (if any): A partial provisional was completed to verify a new wing with 13 dual purpose beds with four of the 13 rooms able to cater for two residents in each (a total of 17 residents). This wing (named RD3) is part of the suite of care cottages as suitable for rest home and hospital level residents. There is a nurse's station, sluice room, medicine cupboard and a dining room in the wing.

Total beds occupied across all premises included in the audit on the first day of the audit: 43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Awa Lifecare Village Limited trading as Te Awa Lifecare provides rest home, dementia, and hospital level care for up to 61 residents. On the day of the audit there were 43 residents living at the facility.

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

A concurrent partial provisional audit was also conducted to verify the addition of a new 13-bed wing (dual purpose beds) to accommodate a total of 17 residents (four rooms [care cottages] can accommodate two residents in each). The wing is connected to the existing hallway in the main building. This will increase the total bed numbers from 61 to 78. This audit has verified the new care cottage wing as suitable to provide rest home and hospital level care. The planned occupancy for the new wing is on the 25 February 2021.

The service is managed by the general manager and clinical manager. The residents and relatives interviewed spoke extremely positively about the care and support provided.

The service has addressed one of the two previous audit shortfalls in relation to timeframes. An improvement continues to be required around completion of neurological observations .

This surveillance and partial provisional audit identified improvements required to the activities programme, to completion of building and furnishings for the new wing, a certificate of compliance and a fire evacuation scheme.

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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Residents and family report that communication with management and staff is open and transparent.

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 medium or high risk and/or unattained 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 with analysis and discussion of data and information through monthly meetings. The risk management programme implemented includes a risk management plan, incident and accident reporting and health and safety processes. Goals are

documented for the service with evidence of regular reviews. Key components of the quality and risk management programme are documented and include management of complaints, an internal audit schedule, completion of satisfaction surveys, analysis of incidents and accidents, and an implemented health and safety programme.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training is in place. The general manager is supported by a clinical manager.

Partial provisional audit: A roster has been provided that includes a registered nurse on each shift in the wing with staff allocated according to occupancy and acuity.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The clinical manager with support from the registered nurses is responsible for the provision of care and documentation at every stage of service delivery. Residents/relatives are involved in planning and evaluating care.

The general manager coordinates activities for the rest home and hospital residents with a diversional therapist recently employed to develop an activities programme for residents in the dementia unit. Community links are maintained.

Medications are managed appropriately in line with accepted guidelines. Staff who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly and as required by the general practitioner.

The kitchen manager (chef) oversees all food services with a four-week menu implemented. Individual and special dietary needs are accommodated. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food provided.

Partial provisional audit: Food services will be provided by the kitchen. A medication cupboard will be stocked to support the new wing.

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.		Some standards applicable to this service partially attained and of low risk.
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Te Awa Lifecare holds a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. The bedrooms, hallways and communal areas are accessible. There are outdoor areas with shade and seating and a secure garden area for the dementia unit.

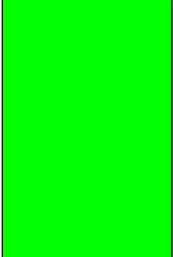
Partial provisional audit: The rooms (care cottages) are fully self-contained with a kitchenette, full ensuite and call bells already installed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents assessed as requiring either the use of restraint or the use of an enabler. Staff receive ongoing education and training in restraint minimisation and managing challenging behaviours.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. There have not been any outbreaks since the last audit. All Covid-19 precautions have been fully implemented.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	20	0	4	1	0	0
Criteria	0	52	0	6	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints procedure to guide practice. The general manager has overall responsibility for managing the complaints process at the service. A record of all complaints can be maintained on VCare (electronic register) and in a hard copy manual. There have not been any complaints to date and residents and family interviewed stated that any improvements are able to be discussed with the general manager or clinical manager. All stated that any improvements suggested are dealt with immediately as issues are raised.</p> <p>Staff interviewed (five healthcare assistants – HCAs, two registered nurses and the kitchen manager/chef) described the complaints process as per the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the organisational policy.</p> <p>The complaints procedure is provided to resident/relatives at entry. Discussion with residents and relatives confirmed they were provided with information on the complaint process. There have not been any complaints from external authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Documentation of accidents, incidents, and complaints; and the policy and</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and to ensure that full and frank open disclosure occurs.</p> <p>Sixteen incident/accident forms were reviewed. The forms included a section to record family notification. All forms confirmed that family were informed of any incident. Five residents including four from the rest home and one hospital resident, and seven family members interviewed (three rest home, two hospital and two dementia) confirmed that relatives are notified of any changes in their family member's health status.</p> <p>A welcome pack is provided to potential residents and family on entry to the service or when there are enquiries into the service. Residents and family interviewed stated that this was useful. Interpreting services can be accessed if 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>Te Awa Lifecare is a new purpose-built facility on the rural outskirts of Cambridge. The service was opened on 1 August 2018.</p> <p>The care centre is across one level and currently includes a total of 32 dual-purpose care centre (hospital and rest home) beds referred to as the care suite (occupancy included 25 residents requiring rest home level of care and seven requiring hospital level occupied on the day of audit), a 12-bed dementia unit (called the Homestead with seven occupied during audit), four care cottages able to accommodate up to seven residents requiring rest home level of care (four rest home residents occupying beds on the day of audit), and a further 10 rest home beds in care cottages (five rooms – no residents requiring care on the day of audit). This gives a total of 61 beds with an occupancy of 43 on the day of audit.</p> <p>One rest home resident and one resident in the dementia unit was using respite services. One hospital resident was under a palliative care contract. One resident in the dementia unit was under 65 years of age and under a young person with disability contract. All other residents were under the Age Residential Related Care contract.</p> <p>Partial Provisional</p> <p>As part of this audit, a new wing connected through the hallway from another existing wing was verified as suitable to provide rest home or hospital level care. Four of the 13 care cottages are large enough for married couples and therefore a total of 17 beds have been verified. The hand over from the builders to the owners is planned for the 31 January 2021 with residents moved into the facility on the 25 February 2021. Total bed numbers with the inclusion of the new wing will be 78.</p> <p>Overall</p> <p>The service is governed by a board of two directors who have experience in owning aged care facilities. Te Awa Lifecare has a strategic executive plan (1 August 2020 to 1 August 2021) and a business plan</p>

		<p>that cascades from the strategic plan.</p> <p>There is a philosophy of care documented. Te Awa Lifecare's vision is 'Helping our people make the most of every day'. There are toolbox updates given by the clinical manager at handover in the afternoon and these talks focus on implementation of core values within the service. Staff state that these are an opportunity to embed values and to positively reinforce staff efforts.</p> <p>An experienced management team is employed to manage the new service. The general manager has extensive experience in managing businesses and is supported by a clinical manager (registered nurse) who has many years' experience in Hospice care particularly as a clinical nurse specialist. The clinical manager is a nurse prescriber and has also completed training in mental health and dementia. The clinical manager has a post graduate diploma in health sciences (advanced nursing) and a Master of Nursing.</p> <p>The managers have maintained at least eight hours annually of professional development activities relevant to their roles.</p> <p>There are no required changes to the governing body of the organisation in light of the new wing being added.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Partial Provisional</p> <p>In the absence of the general manager, the clinical nurse manager is in charge, noting that the general manager stated that they would remain in contact at all times. The clinical nurse manager is supported by a registered nurse with experience in aged care when on leave.</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</p>	FA	<p>The general manager advised that they are responsible for providing oversight of the quality programme with the role described in the policy. There is a quality plan that is ratified by the Board of Directors. Quality objectives are documented and linked to the dimensions of quality such as resident centred and equitable, and resident service delivery with progress discussed at staff meetings. The objectives align with the strategic executive plan 2020 to 2021 with progress also reported to the Board of Directors. Objectives are reviewed as per dates documented against each and annually.</p> <p>The service's policies are reviewed two yearly or as changes occur, with input from the general manager</p>

<p>improvement principles.</p>		<p>and clinical nurse manager. Staff have access to manuals.</p> <p>The quality programme includes an annual internal audit schedule that is implemented. Audit summaries and corrective action plans are documented where a non-compliance is identified. Issues and outcomes are reported through the monthly staff and head of department meetings. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner. All aspects of the quality and risk management programme are included on the agenda of the staff meetings. Resident meetings are held quarterly with opportunities for relatives to have input into the service through the open-door policy of the general manager. Family are invited to the resident meetings.</p> <p>A resident/family satisfaction survey completed in January 2020 evidenced a high level of satisfaction with the service. All questions in the survey were rated as satisfied or very satisfied with 88% of respondents stating that they were very satisfied with support for their individual needs. There were no areas identified for improvement in the survey results.</p> <p>The service has a risk management and health and safety management system. Strategies to prevent falls include call bells in reach of the resident, non-slip mats for ensuites, seat and bed sensors, perimeter mattresses, low low beds, and bed levers to support residents to reposition themselves. There are implemented policies and plans in place, including accident and hazard management. The hazard register is current and reviewed annually with any new hazards added as these are identified. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required.</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>	<p>PA Moderate</p>	<p>There is an accidents and incidents reporting policy. The general manager and clinical nurse manager investigate accidents and near misses and provide an analysis of trends on a monthly basis. The clinical manager conducts clinical follow-up of residents.</p> <p>Sixteen incident forms sampled from the past two months in 2020 included appropriate follow-up by the clinical manager and investigation of incidents to identify areas to minimise the risk of recurrence. Monthly analysis of incidents by type has been undertaken by the service and reported to meetings. Neurological observations are not documented as per policy for any resident with a fall involving a head injury or for an unwitnessed fall. The shortfall identified at the previous audit remains.</p> <p>Senior management are aware of the requirement to notify relevant authorities in relation to essential notifications. There has been one Section 31 notification to the Ministry of Health since the last audit around a 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>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, and staff training and development.</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and skills. A copy of practising certificates is kept for staff and external health providers, with all current.</p> <p>Five staff files were reviewed (the clinical manager, two registered nurses, and two healthcare assistants) and all included all appropriate documentation. This included a contract relevant to the role, a job description and evidence of orientation and training. Performance appraisals are completed annually.</p> <p>Healthcare assistant and registered nurse staffing levels are stable. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. New staff interviewed stated that they had an in-depth orientation programme that included reading of policies and a buddy system that was in place for at least three weeks.</p> <p>There was an implemented in-service calendar for 2020 which exceeded eight hours annually for staff who attended the training offered. The service has now got four registered nurses who are interRAI trained with the general manager and the clinical manager also trained in the management component of interRAI. This has enabled the service to complete interRAI assessments in a timely manner.</p> <p>There are a total of 56 staff employed at the service including 22 healthcare assistants (and a further five casual HCAs); 10 registered nurses; general manager (activities staff) and diversional therapist for the dementia unit; clinical manager; kitchen manager/chef, a second chef and kitchen staff; and four household staff. Other staff include administrators and maintenance staff.</p> <p>There are six HCAs who are consistently rostered onto the dementia unit and all have NZQA level four dementia standards. There are a further seven with level four qualifications with three enrolled in training for level four. There are six HCAs who have completed level three and one who has completed level two.</p> <p>Partial Provisional</p> <p>Any new staff will attend an induction programme when they start in the service. This will include fire safety, manual handling, first aid, fire drill, emergency management, complaints, and medication/Medimap as part of the core training. Core competencies will continue to be required to be completed annually as per policy.</p> <p>There are sufficient staff already on the roster to cover the initial occupancy of the new wing. This includes casual staff (RNs and HCAs) who will take on full time or part time roles with the opening of the new wing. There are advertisements already in place for casual staff.</p>
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<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>There is a policy that includes staff rationale and skill mix. A review of rosters (the past three months in 2020) confirmed that there are sufficient staff rostered and staff are replaced when on leave.</p> <p>Staffing is as follows for the 32 dual-purpose bed care centre (two wings identified as RD1 [19 beds] and RD2 [13 beds] and for the four residents in the care cottages: five HCAs in the AM, four in the PM and one overnight. There are also two RNs in the AM, one in the afternoon and one overnight. The clinical nurse manager is in the unit Monday to Friday and as required. Staffing in the unit is adjusted for acuity and resident numbers. All rooms in the care cottages (currently occupied by four residents) are linked by a hallway to the rooms in the care centre.</p> <p>In the dementia unit (Homestead), there are two HCAs in the AM, one in the afternoon and one overnight. RNs work in the unit for at least three hours a day, seven days a week. The clinical manager also works in the dementia unit to oversee practice and care planning each day during the week.</p> <p>There is an on-call process for after hours and staff are aware of how to escalate any concerns. Currently the clinical nurse manager is on call with a registered nurse able to provide backup on call if required. The general manager stated that they live on site and are always able to be contacted.</p> <p>Partial Provisional</p> <p>There is a staffing plan in place that includes a registered nurse on each shift and at least one HCA rostered on for 0-10 residents, with staffing increased when there are 10-17 residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses administer medications and medication competent carers check medications when required. These staff have been assessed for competency on an annual basis and attend annual medication education.</p> <p>The service uses an electronic system to prescribe and record administration of medications. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored either in the residents locked drawers or in the medication room. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were two residents self-medicating on the day of audit. Self-medicating competencies were being completed 3-monthly.</p> <p>The ambient temperature of the medication room is recorded. The temperature of each bedroom is monitored and recorded to confirm that this does not pass 25 degrees Celsius. Vaccines are not held on site. Standing orders are documented as per Ministry of Health guidelines with the last review completed</p>

		<p>in November 2020.</p> <p>Ten medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication around.</p> <p>Partial Provisional</p> <p>There is a medication cupboard in the new wing that will hold resident medications if required. This has yet to be locked with equipment and furnishings put in.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked on site for Te Awa Lifecare. The Food Control Plan expires on 7 February 2021. Te Awa Lifecare has a large kitchen with a receiving area and food preparation and dish washing area. A qualified chef (kitchen manager) works Monday to Friday. The sous chef works Sunday to Thursday. There are two kitchen hands employed. Kitchen staff have completed food safety units and other relevant training.</p> <p>The menus are seasonal and rotate on a four-weekly basis. The menu has been audited and approved by a dietitian. There are snacks available throughout the day. Residents can choose to have breakfast in their room. All residents have a fridge, microwave, and kitchenette available in their rooms. Cultural preferences and special diets are met including pureed diets and high protein diets. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Food is transferred from the kitchen in hot boxes and served in resident's rooms or in one of the dining rooms.</p> <p>Fridge and freezer temperatures are recorded daily. There is evidence that food temperatures are taken and recorded daily or for any hot meal. All temperatures are recorded in a computer programme. All foods were date labelled and stored correctly. A cleaning schedule is maintained, this was sighted. Residents and family members interviewed were happy with the food served and range of options available. Alternatives are offered for dislikes.</p> <p>There is a lounge/dining table area at the end of the wing. In addition, each resident has a dining room / lounge within each apartment. Residents have the choice of where they would like to eat.</p> <p>Residents interviewed were highly complementary of food services.</p> <p>Partial Provisional</p> <p>Food services will be as per usual with an additional hot box already purchased.</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>The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse practitioner (NP) visit if required. There is evidence of three-monthly medical reviews, or the GP/NP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were 12 wounds being treated on the day of the audit. One resident had four wounds; and two residents had two wound each. There were two pressure injuries (one stage three for a resident in the dementia unit, and one stage one). Wound assessments and a wound management plan for each wound had been completed for all wounds. There was evidence of GP involvement for all wounds and the GP confirmed knowledge of status of the wounds. Two residents with wounds that were hard to heal were seen at least six-weekly by the wound specialist. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. The long-term care plans and active short-term care plans are in the electronic software system, 'VCare' used for resident care.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>Activities for residents occur daily on a group or one to one basis. The activities programme is designed to reflect residents' interests. The 'Care Suite calendar' displays the group activities scheduled for residents in the care suite with the same plan used in the dementia unit. A personal activities assessment is completed after admission in consultation with the resident and/or family/whānau on entry to the service. The long-term plan in V Care includes strategies to support social engagement and activities with strategies reflective of the assessment which had captured the resident's interests, career, and family background. A record is kept of individual resident's activities. The activity sections of the care plan are reviewed six-monthly.</p> <p>One to one and group activities are provided. The one-to-one activities are focused on the resident's personal interests. Community access includes van trips. Community involvement includes engagement with the Te Awa village and the wider community. Families and residents interviewed reported they enjoyed the activities programme. Popular activities include happy hour, exercises (adapted in the dementia unit to include balloon games), outdoor activities and musical entertainment. There are frequent</p>

		<p>'special' activities that reflect events such as Xmas, birthdays, Diwali etc. Detail of the programme for residents in the dementia unit is not documented on the activities plan.</p> <p>The general manager has experience and qualifications in event planning and management and has taken the role of activities coordinator for the rest home and hospital residents. This role takes 15-20 hours per week. A DT has been employed to develop the 24-hour activity plans for residents in the dementia unit and to plan and provide activities for this group of residents. Twenty-four-hour plans are started for each resident in the dementia unit with these documented for the morning and afternoons. The DT is recently been employed for four days a week, from 0700-1530 and will eventually oversee the activities programme across the service.</p> <p>A residents meeting is held quarterly, and residents identify activities they would like to be included. The weekly activities plan is displayed in the facility and family are sent out the programme so that they can also engage in events and activities. Family and residents interviewed stated that they enjoyed the programme. There are also activities on the site that they also enjoy being engaged in e.g., hen house and other animal care (sheep), gardening, walking around the property. Residents were observed to be engaged in a range of meaningful activities that encouraged social, physical, and mental wellbeing.</p> <p>Partial Provisional</p> <p>The activities plan in place for the rest home and hospital residents will roll out to include residents in the new wing. The general manager states that existing staff will take the activities programme with the view to increasing numbers as required when occupancy increases past five depending on acuity and independence.</p>
<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>Initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed in resident files sampled. Long-term care plans are reviewed six-monthly and as changes occur. Short-term care plans have been evaluated against desired goals. Ongoing nursing evaluations are documented in the progress notes as required and at regular intervals. Family are involved in care plan review and informed of any changes. There is at least three-monthly medical evaluation of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected</p>	<p>FA</p>	<p>Partial Provisional</p> <p>There are policies around waste management. Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. There is a cleaning, disinfection, and sterilising policy.</p>

<p>from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Material safety datasheets are to be available in the laundry and the sluice. Personal protective equipment is arranged to be in place by a contracted supplier. There is a secure sluice which will include a sluice and sink (link 1.4.2.4). The staff will access the existing locked cleaner's cupboard in the care centre. Advised, that a sharps container will be kept in the medication cupboard.</p> <p>Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.</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 12 July 2021.</p> <p>Reactive and preventative maintenance occurs. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment, and safety checks. Electrical equipment has been tested and tagged and calibration of medication equipment is completed annually. Essential contractors are available 24-hours a day. Fire equipment is checked by an external provider.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>The dementia unit is secure. There are large spaces in the unit for resident activities to take place. There are large outdoor areas that include gardens, outdoor furniture, a hen house, and farm gates. This encourages residents to engage in activities that are meaningful to them from their past.</p> <p>Partial Provisional</p> <p>The new wing is purpose-built with spacious rooms. All building and plant have been built to comply with legislation. The wing is attached to the existing care cottages/wings with a continuation of the wide hallways. Each care cottage in the wing includes a large bedroom (four of which are large enough to include two beds each with a call bell), lounge and dining area, ensuite with call bells and a kitchenette. Each has a courtyard for outdoor living. The four rooms have been designed for hospital level or rest home level of care.</p> <p>Residents are able to bring their own possessions into the home and are able to adorn their room as desired.</p> <p>There are handrails in ensuites, communal bathrooms and hallways. All rooms and communal areas allow for safe use of mobility equipment. The facility is carpeted throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. There is adequate space in each new wing for storage of mobility</p>

		<p>equipment.</p> <p>The wing is in the process of being furnished. The code of compliance has been signed off post on-site audit. This was sighted and dated 12 July 2018.</p> <p>The service has purchased new equipment for the facility including hoists, pressure injury mattresses, hi/lo beds, and oxygen cylinders, and bottles. All rooms to have electric hi/lo beds (large single beds). The maintenance schedule includes checking of equipment. All electrical equipment and other machinery is to be checked as part of the annual maintenance and verification checks.</p> <p>There are environmental audits and building compliance audits, which will be completed as part of the internal audit. The existing maintenance staff will be used to monitor and attend to any reactive maintenance issues.</p> <p>While the rooms are built, there are final steps to be taken to complete each room. This will also include furnishing each room and installation of household equipment.</p> <p>The new wing requires a code of compliance.</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>Partial Provisional</p> <p>Each room has a full ensuite with equipment due to be installed (link 1.4.2.4). The ensuite in each room is spacious with shower and toilet, drawers, and cupboards for own linen etc. Communal toilets are not required in the wing as each has these in their room and visitors and staff can access toilets in existing wings adjacent to the new wing. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment.</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>Partial Provisional</p> <p>Residents' rooms are spacious and designed for hospital level of care including the four rooms that can cater for two residents in each at hospital level of care. Each room allows for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and communal toilets/bathrooms in all areas. The dining/ lounge area in each room is spacious with additional space in the double rooms. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, bed, lazy boy, or wheelchair.</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>Partial Provisional</p> <p>There is a dining/ lounge in each room. Visitors and residents can also access communal dining/lounge areas in other wings if they wish with seating available to cater for additional numbers. There is also a smaller whānau room/lounge at the end of each wing that can be accessed by visitors and residents. There is a large village communal lounge/café/dining area by reception and connected to the care facility that can be accessed by residents/family.</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>Partial Provisional</p> <p>There are laundry policies and procedures. Cleaning procedures are available for cleaning staff. The spacious laundry is situated in the main service area and will be used by staff servicing the new wing. There are two doors into the existing main laundry (entry and exit) and the laundry is designed with a dirty and clean flow and an area for folding and storage of clean linen. Industrial washing machines and dryers and covered linen trolleys are already in use. A closed system to supply chemicals to the machines is in place and MSDS are available. The existing cleaners/laundry staff will also clean and complete laundry for residents in the new wing.</p> <p>There is an internal audit around laundry services and environmental cleaning completed twice as part of the internal audit schedule and this will include the new wing. The cleaner's cupboards in the existing building are designated areas and lockable for storage of chemicals and are stored securely.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Partial Provisional</p> <p>Appropriate training, information, and equipment for responding to emergencies is provided at induction and is included as part of the annual training programme. Staff to be rostered onto the new wing are already trained in fire safety and have completed six monthly fire drills. The new wing is of a similar design to existing care cottages and staff will be oriented to the new wing once open.</p> <p>There are comprehensive civil defence and emergency procedures in place. There are civil defence kits and large water tanks available.</p> <p>Key staff hold a first aid certificate on each shift.</p> <p>Smoke alarms, sprinkler system and exit signs are in place in the building. There is a fire evacuation scheme in place for the existing site however the fire evacuation procedure for the new wing has yet to be</p>

		<p>finalised. This is in draft and currently with the fire service awaiting approval. Smoke alarms, sprinkler system and exit signs are in place in the wing.</p> <p>The existing facility has emergency lighting and torches, a generator, gas BBQ and additional cylinders for alternative cooking.</p> <p>There is a security policy in place. The service has a mobility van and there is a transportation policy that links to residents outing policy and vehicle driver competency assessment.</p> <p>Call bells are available in all resident rooms, (above each bed and in ensuite toilet/showers, lounge/ dining room) with a separate call bell for each resident by the bed in the four rooms verified as being able to have two residents in each. The call bell system is connected to pagers already carried by each staff member. The call bells are in place but will need to be operationalised as they are temporarily switched off.</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>Partial Provisional</p> <p>The new wing is appropriately heated and ventilated. There are radiators and overhead heat pumps in the new wing. The temperature in each room can be individually set. There is plenty of natural light in the rooms and all have windows or sliding doors.</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 IC programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. There is a suite of infection control policies and procedures. The infection prevention and control programme policy includes infection control objectives and lines of reporting. The infection control and surveillance monitoring policy describes the surveillance programme to be implemented.</p> <p>There is a job description for the infection prevention & control (IP &C) nurse and clearly defined guidelines. The IP&C nurse is the clinical nurse manager. The infection control programme is designed to link to the quality and risk management system. The programme is reviewed annually.</p> <p>The IC committee includes staff from across all areas with discussion at the staff meeting.</p> <p>There is a pandemic management policy, outbreak management plan and template and staff health policy.</p> <p>The infection control education policy describes education to be provided to staff, residents, and families.</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 surveillance is an integral part of the infection control programme and is described in the service's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly through meetings and outcomes and actions are discussed.</p> <p>There have been no outbreaks since the previous audit. There are adequate resources kept on site for any outbreak of two weeks. This includes personal protective equipment in the event of Covid 19. Staff have had comprehensive training around Covid 19 and can describe management of any identified case.</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>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p> <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There are no residents using either restraint or an enabler. Enabler use would be voluntary. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. The clinical nurse manager monitors any potential use of restraint or enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>There is a documented expectation in policy to complete neurological observations for any resident with a fall involving a head injury or for an unwitnessed fall. Of the sixteen incident forms reviewed, 12 should have had neurological observations documented as per policy for any extended period. Two of the six forms confirmed that neurological observations were taken and documented as per policy. Staff stated that at times residents refused to have neurological observations completed or developed challenging behaviour, however this was not documented as having occurred on incident forms or in progress notes reviewed.</p> <p>The clinical manager has put training in place since the last audit to try and improve documentation of neurological observations. All staff have signed to state that they have read and understood the relevant policy. Staff meeting minutes reviewed also indicated that incidents are discussed, trends reviewed and strategies to improve falls management</p>	<p>Ten of 12 incident forms for a resident with a fall involving a head injury or for an unwitnessed fall did not have neurological observations taken and documented as per policy.</p>	<p>Ensure that neurological observations are documented as per policy for any resident with a fall involving a head injury or for an unwitnessed fall.</p>

		for individual residents is discussed. This included reference to the importance of taking neurological observations as per policy. Registered nurses interviewed could describe the policy. The risk rating remains as moderate to recognise the work already put into ensuring that the policy is followed.		90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	There is a medication cupboard being built in the new wing verified on the day of audit. This is partially completed.	The medication cupboard in the new wing does not yet have a lock and requires furnishings.	<p>Lock the medication cupboard in the new wing and furnishing appropriately</p> <p>Prior to occupancy days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	The activities plan is across the organisation. While there are general activities referenced in the plan that can be adapted for residents in the dementia unit, there is no specific plan for the dementia unit that would reflect activities that may be enjoyed more by residents in the unit. A DT has been employed for four days a week to develop the programme further for residents in the dementia unit and to document 24-hour activity plans for each resident. A 24-hour activity plan has been developed for each resident however this only includes activities from 0700-2200.	<p>(i). The activities plan is not yet adapted to include activities more relevant to residents in the dementia unit.</p> <p>(ii). 24-hour activity plans are not yet completed fully for all residents in the dementia unit.</p>	<p>(i). Develop and implement an activities plan is that is relevant to residents in the dementia unit.</p> <p>(ii). Document 24-hour activity plans for all residents in the dementia unit.</p>

				180 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	A code of compliance has not yet been issued for the new wing.	A code of compliance will be required prior to opening the new wing.	<p>Provide a code of compliance prior to opening the new wing.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	Rooms are built however there are final touches required to furnishings, carpentry, and installation of equipment e.g., the sluice, kitchenette, ensuite etc.	Rooms are built however there are final touches required to carpentry, completion of furnishings and installation of equipment.	<p>Complete final building of the rooms, furnish and install equipment.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	While staff have completed training if emergencies, they have not yet been orientated to the new wing.	Staff have not yet been orientated to the new wing and to emergency management.	<p>Ensure that staff are orientated to the new wing and to emergency management.</p> <p>Prior to occupancy days</p>

<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA Low</p>	<p>There is a fire evacuation scheme in place for the existing site however the fire evacuation scheme for the new wing has yet to be finalised. This is in draft and currently with the fire service awaiting approval.</p>	<p>A fire evacuation scheme is yet to be finalised for the new wing.</p>	<p>Ensure that there is a fire evacuation scheme finalised for the new wing.</p> <p>Prior to occupancy days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.