Karaka Court Limited - Woodlands of Palmerston North

Introduction

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

The audit has been conducted by 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:	Karaka Court Limited
Premises audited:	Woodlands Of Palmerston North
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 August 2021 End date: 17 August 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 21

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

General overview of the audit

Woodlands of Palmerston North is certified to provide care for up to 42 residents at rest home and secure dementia levels of care. On the day of audit there were 20 residents.

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

The service is managed by a non-clinical manager and a clinical nurse leader. The 2021-22 business plan, quality and risk plan and operational quality goals reflect evidence of goals being regularly reviewed with progress on goal achievement addressed in the monthly staff meetings. Residents and relatives interviewed spoke positively about the service provided.

The audit identified an improvement required around human resource management.

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.

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff have access to training about the Code. The personal privacy and values of residents are respected. Individual care plans reference the cultural needs of residents. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their health status. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. Quality and risk management programmes are embedded into practice. Data is collected, analysed, and discussed with staff. Quality improvement plans are developed when service shortfalls are identified. Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff. There is an annual education and training plan that is established. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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.		Standards applicable to this service fully attained.

The clinical leader is responsible for the provision of care and documentation at every stage of service delivery. There is a three-monthly general practitioner or nurse practitioner review. The diversional therapist implements the activity programme which meets the individual needs, preferences, and abilities of residents. One on one time is spent with residents in the dementia unit. Community links are maintained. There are regular entertainers, outings, and celebrations. Medications are managed appropriately in line with accepted guidelines; the clinical leader and medicine competent caregivers administer medications.

All meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are additional snacks available. The service has a food safety plan, and the seasonal menu is audited by a registered dietitian.

Safe and appropriate environment

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

The building holds a current warrant of fitness. Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. External areas are safe and well maintained. There is adequate lounge, dining areas and seating areas available for residents and visitors. Fixture's fittings and flooring is appropriate, and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate

training, information, and equipment for responding to emergencies are provided. The facility has civil defence kits and emergency management plans.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were no residents with a restraint, and one resident using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. There are appropriate policies and guidelines for the scope of the programme. The infection control nurse is the clinical leader who is responsible for providing education and training for staff. Infection control training is provided on orientation and ongoing. Surveillance of infections occurs, and this is communicated to staff.

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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English and te reo Māori. Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service education programme (link 1.2.7.5). Interviews with the managers (manager/owner, administration manager) and eight staff (four caregivers who work both the AM and PM shifts in the rest home and dementia units), one clinical leader/registered nurse (RN), one diversional therapist, one maintenance, and one cook) confirmed that they understand the Code and could provide examples of its application to their job role and responsibilities. Four residents (rest home) and three relatives (two rest home, one dementia) confirmed that staff respect their privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	FA	There are policies around informed consent. Completed informed consent and resuscitation forms were evident on all resident files reviewed and they were all valid. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for activities of daily living and nursing cares. Enduring power of attorney (EPOA) evidence was sought prior to admission and activation documentation was obtained. This was evident in the dementia level care files reviewed. Consent forms were signed by the resident or their EPOA.

give informed consent.		Resuscitation forms were signed by the resident or resuscitation decision was noted as “medical decision”. Family interviews confirmed that they are given good information to be able to make informed choices. Resident’s files reviewed had a signed admission agreement.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Brochures explaining the role of advocacy services are available at the entrance to the facility. Also posted at the entrance are the contact details for three different advocacy agencies. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on resident’s family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting hours. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaint policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance to the service, alongside brochures explaining the complaints process and advocacy services. Residents interviewed confirmed they received information on the complaints process on admission and the management team are very approachable should they have any concerns/complaints. Care staff interviewed are aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained. One complaint was lodged with the Health and Disability Commissioner (HDC) in August 2020 and has been closed. Corrective actions implemented include ensuring adequate hand hygiene stations are available throughout the facility and providing health screening at the entrance to the facility. Additional corrective actions implemented in the event the facility is placed in a level two lockdown include locking the front door when reception is not attended, and ensuring visitors are allowed to be isolated when visiting family in the dementia wing. No other complaints were lodged in 2020 and no complaints have been lodged (year-to-date) in 2021.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The RN or manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope.
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.	FA	A tour of the premises confirmed there are areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Caregivers interviewed could describe definitions around abuse and neglect that align with policy, promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Caregivers could describe how choice is incorporated into resident care.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The Māori health plan references local Māori healthcare providers and provides recognition of Māori values and beliefs. One director identifies with Ngata Ruanui iwi. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. During the audit, there were three residents who identified as Māori living at the facility. Ethnicity is identified in their individual resident file. None of the residents and/or whanau listed any preferred and/or specific cultural preferences. Residents and their whanau were not available to be interviewed.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Individual beliefs or values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met, and family/whānau are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of an employment agreement that covers a code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional when carrying out their duties. Interviews with care staff described how they build a supportive relationship with each resident. Residents and the relatives interviewed stated they are treated fairly and with respect by staff.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures are aligned with current accepted best practice. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. The staff are committed to providing a service based on the mission statement and philosophy of care, observed during this two-day audit. The staff demonstrate a caring attitude towards the residents. Staff meetings enhance communication and provide consistency of care. The service is actively working on reducing the number of residents' falls, residents' infections and other adverse events. Staff are kept informed via handover which occurs between shifts. The clinical leader/RN works closely with clinical staff at Woodlands of Feilding, a second aged care facility owned by the same directors. The service prides itself on providing a home-like environment and individualised care. Residents described feeling very safe and secure and reported feeling at home. Satisfaction survey results indicate that both residents and families are satisfied or very satisfied with the services received.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Resident files reviewed contained evidence of family communication. Relatives interviewed confirmed they are notified following a change of health status of their family member. Staff are required to record family notification when entering an incident/accident into the system, evidenced in all fifteen incident/accident reports reviewed. There is an interpreter policy in place and contact details of interpreters are available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	Woodlands of Palmerston North is certified to provide care for up to 42 residents at rest home and secure dementia levels of care. Three rooms certified as double rooms are being used as single rooms and a fourth single room is being used as a staff room. On the day of audit there were 9 rest home level residents, one boarder in a rest home level room and 11 residents in the dementia unit. There was one rest home level resident on a young person with a disability (YPD) contract and one boarder who does not require assistance with care. All remaining residents were under the age-

consumers.		related residential care (ARRC) contract. The two company directors of Karaka Court Ltd operate two facilities, Woodlands of Palmerston North and Woodlands of Feilding. The 2021-22 business plan, quality and risk plan and operational quality goals reflect evidence of goals being regularly reviewed with progress on goal achievement addressed in the monthly staff meetings. The service is managed by an experienced manager/owner (non-clinical) who has been in this role for the past eleven years. She is supported by an administration manager (non-clinical) and a clinical leader/RN. The clinical leader has been in her role for one year and has worked in aged care for over four years. The administration manager has been in her role for one year. The managers have maintained at least eight hours annually of professional development activities related to their roles in managing a rest home and dementia care facility.
Standard 1.2.2: Service Management 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.	FA	The clinical leader and administration manager cover during the temporary absence of the manager. An RN from the Feilding location covers for any absence of the clinical leader.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the managers and staff reflect staff involvement in quality and risk management processes. Staff meetings and resident meetings are conducted monthly. Comprehensive meeting minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The July 2021 resident/family survey reflected that overall, residents and families are either satisfied or very satisfied with the service provided. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at least two-yearly with infection control policies reviewed annually. The quality monitoring programme is designed to monitor contractual and standards compliance and service delivery. There are clear guidelines and templates for reporting. The facility collects,

		analyses and evaluates data. This is utilised for service improvements. Action plans are developed when service shortfalls are identified and are monitored until rectified and signed off. Health and safety policies are implemented and monitored by the manager. Health and safety is addressed in the monthly staff meetings. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to staff so that improvements can be made. Staff and external contractors are orientated to the facility's health and safety system. Falls prevention strategies are in place including (but not limited to): sensor mats; increased monitoring; and identification and meeting of individual needs.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective actions to minimise reoccurrence. Adverse events are discussed during staff handovers and in staff meetings. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Fifteen incident/accident reports reviewed met this requirement (twelve witnessed and unwitnessed falls, two episodes of challenging behaviours, one skin tear). Neurological observations are implemented if there is a suspected injury to the resident's head or if the fall is unwitnessed. Adverse events reviewed reflect follow-up and sign-off by the clinical leader. The manager was able to identify situations that would be reported to statutory authorities. Section 31 reports were sighted for a change in managers and one resident with an infectious disease.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical leader, five caregivers) included signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. Missing was consistent evidence of reference checking (note: the files selected were of staff employed since the previous audit). Health practitioner practising certificates are maintained. The orientation programme provides new staff with relevant information for safe work practice. There is a two-yearly education and training plan that exceeds eight hours annually although staff attendance has been low for some sessions. Advised that staff that do not attend read and sign the content. Questionnaires are completed to determine understanding. The clinical leader is interRAI

		trained. Five caregivers hold a level four (or higher) Careerforce qualification (or its equivalent), six hold a level three qualification and one a level two qualification. Eleven caregiver staff work in the dementia unit. Four have completed the required dementia Careerforce standards. Five are in the process of completing theirs and two have yet to begin training. The seven staff who have not completed a dementia qualification have been employed to work in the dementia unit for less than 18 months.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The clinical leader and administration manager (non-clinical) are on-site Monday to Friday. The manager is also onsite the majority of days of the week, sharing time between this facility and their second aged care facility in Feilding. The clinical leader is on-call 24/7 when not on-site. Dementia unit (11 residents): AM: two caregivers on full shifts, PM: one caregiver on a full shift and one caregiver on a short shift (to 2030), Night: one caregiver. Rest home (9 residents): AM: one caregiver on a full shift and one caregiver on a short shift (to 1330), PM: one caregiver on a full shift and one caregiver on a short shift (to 2030), Night: one caregiver. Caregiving staff are also responsible for laundry. Cleaning staff work five days a week, four hours a day. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing. The manager reported that the staff who are working a short shift may have their hours changed based on resident acuity. The manager, administration manager and clinical leader reported that staff are very helpful in filling any gaps to cover sick leave and holiday leave.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or clinical leader including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is	FA	Residents are assessed prior to entry by the need's assessment coordinators and, where required, the psychogeriatric team. The clinical leader liaises closely with the assessing teams to ensure Woodlands of Palmerston North can meet the prospective resident's needs. Family members

facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		interviewed stated that they received sufficient information on the services provided and are appreciative of the staff support during the admission process. The admission agreement form in use, aligns with the requirements of the ARRC contract and exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Discharge planning and transfer policy guide staff in this process. Discussions with the manager and clinical leader confirmed that resident exit from the service is coordinated and planned, and relevant people are informed. There is sufficient information to assure the continuity of residents' care through the completed forms, copies of relevant progress notes, the medication chart and doctor's notes. Where a resident is hospitalised, a staff member or family member (as appropriate) accompanies the resident to the hospital. Follow-up occurs to check that the resident is settled or, in the case of death, communication with the family is made and this is documented.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The service uses robotic medication packs and an electronic charting system. Medications are checked on arrival by the clinical leader and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely. Staff sign for the administration of medications on the electronic system. There were no expired medications in the medication cupboard or in the fridge. All 12 medication charts reviewed had photo identification and allergies noted. 'As required'(PRN) medications had prescribed indications for use. The effectiveness of PRN medications was recorded on the electronic system and in the residents' progress notes. Medication charts had been reviewed by the GP or NP three monthly and the clinical leader reviews all PRN medication administration on a daily basis. The clinical leader or senior caregivers administer medication in both areas. Annual medication competencies were completed. The clinical leader advised there were no residents self-medicating on the day of audit. The service has policies and procedures in place for ensuring all medicine related recording and documentation meets acceptable good practice standards. The medication fridge is monitored daily and recorded. Room temperature monitoring has been commenced on the first day of audit.

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.	FA	There is an approved Food Control Plan which expires 17 July 2022. The kitchen food control plan covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The kitchen/server area is adjacent to the main dining room. There are three cooks who cover seven days a week; cooks hold NZQA unit standard 167 and safe steps training. All residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six-monthly review. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. There is a summer and winter menu. The menu rotates four weekly and is designed and reviewed by a registered dietitian, last review was 2021. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving. Meals are served directly from the kitchen to the residents in the rest home dining room. Meals are delivered in a hot box to the residents in the dementia unit. There is evidence that there are additional nutritious snacks available in the unit over 24 hours for dementia residents. Equipment is available on an 'as needed' basis. Residents requiring extra assistance to eat, and drink are assisted by caregivers, and this was observed during the lunch service.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service records the reason for declining service entry to residents, should this occur, and communicates this decision to prospective residents/family/EPOA. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. The service currently has vacancies.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All resident's records reviewed had appropriate assessments on admission. Needs, outcomes and goals of residents were identified through the assessment process. Residents and family are consulted and agree to intervention outcomes. Additional assessments for management of behaviour, falls risk, pressure injury and wound care were appropriately completed on admission and thereafter as required. On the day of the audit, the momentum interRAI dashboard showed that all interRAI assessments were current. A sample of six resident's (including the resident on the YPD contract) interRAI assessments confirmed that all were completed within the required timeframes. The outcomes of

		interRAI assessments, including the risk assessments, were reflected in the long-term care plans. Files sampled from the dementia unit evidenced that behaviour assessments and management plans were all documented in the residents' records as needed. The clinical leader has completed interRAI training.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans were developed and reviewed by the clinical leader. Sampled plans reviewed evidenced that they were developed in consultation with the resident (as appropriate), family and caregivers. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process and family members interviewed confirmed that they are involved in the process. The outcomes of interRAI assessment forms the basis of the long-term care plan. Short-term care plans were used for short-term needs. Dementia residents' records showed residents current abilities, level of independence, identified needs, and specific behavioural management strategies. All dementia residents' records had comprehensive behaviour management plans that had been reviewed and updated.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Interviews with staff, residents and relatives identified that the care that is being provided is consistent with the needs of residents. Monitoring charts and behaviour monitoring charts were sighted in files sampled. Care plans reviewed all reflect the individualised care needs for residents. A number of GPs provide services for the facility; however, a high number of residents are seen by a NP who provides weekly on-site visits and is available on call. There is an afterhours GP service available from a local practice. The NP interviewed expressed high confidence in the clinical leader and caregivers and described specialist input into the resident's care in the dementia unit. Dressing supplies are available, and a treatment room/cupboard is stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. There were two residents with wounds (skin tear) in the dementia unit. Wound care management records were up to date. There were no pressure injuries. The clinical leader described the assessment, planning and evaluation process should there be a complex wound along with the referral process should assistance from a wound specialist be required.
Standard 1.3.7: Planned Activities	FA	There is a qualified diversional therapist (DT) providing activities in the rest home and the dementia

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.		unit. Two separate monthly activity programmes are developed, one for the rest home and one for the dementia unit. The DT works 40 hours per week Monday to Friday. Caregivers in the dementia unit support the DT with implementation of the programme. On the day of audit, residents were observed being actively involved with a variety of recreation activities in the rest home and in the dementia unit. The daily programme was displayed in the reception area. Residents' records reviewed had an activities/social profile assessment including a complete history of past and present interests, and family information. The DT offers joint activities in the rest home lounge with dementia level care residents. Activities are age appropriate and planned. There are several programmes running that are meaningful and reflect ordinary patterns of life. The facility van goes out three times per week taking residents for drives and events in the community. Residents provide regular feedback to the activity staff around their activity programme likes and dislikes of the through residents' meetings or following activity events. Resident records reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. There was one resident under YPD contract who is over 65. The DT reported specific resident directed activities and community outings for this resident. The DT and the caregivers could describe strategies for the provisions of a low stimulus environment in the dementia unit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Progress notes were being consistently documented at each shift and these were reviewed by the clinical leader. Short term care plans were documented, and these were communicated to caregivers. Short term care plans were signed off when the issue was resolved. Care plan reviews were completed six monthly or earlier, and document progression towards meeting goals. There were also three-monthly medical reviews which were completed by GP/NP. Family members were updated following these reviews. Families interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment, and psychogeriatric teams.

disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has policy and procedures in place for the management of waste and hazardous materials and to support the safe disposal of waste and hazardous substances. These include (but are not limited to): a) sharps procedure, b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. Training is provided to the staff around safe management, as part of the annual training plan. Chemicals were labelled, and there was appropriate protective equipment and clothing available to staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness which expires on 4 April 2022. Facility generated requests for maintenance services are undertaken by the maintenance person, who also organises external contractors to undertake work if this is necessary. The reactive maintenance request book is sighted, this shows that maintenance requests were completed and signed off. The planned maintenance schedule includes calibration of medical equipment, functional testing of electrical equipment, and hot water monitoring. Hot water temperatures in resident areas are stable below 45 degrees Celsius. The rest home part of the facility has two levels and access to the upper floor is facilitated thorough stairs and a lift. Residents were observed using the lift safely. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. The secure dementia unit has a separate lounge and dining area, which were both well-supervised on the day of audit. There is a secure outside/garden area. The external areas are well maintained and residents in both wings have easy access to gardens and indoor areas. There are two designated smoking areas. Three residents smoke and staff monitor resident's safety during smoking.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured	FA	Residents in both units share communal bathrooms and toilets within their unit. There were sufficient numbers of these facilities, toilets are located near resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets and showers were well signed and identifiable.

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms differ in size and are appropriate for rest home and dementia level care. Residents were able to manoeuvre mobility aids around the bed and personal space. Caregivers interviewed, reported that rooms have adequate space to allow cares to take place.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are separate lounges/dining rooms in both units and, a small seating area by the reception. These are well proportioned and can accommodate the lounge furniture and dining tables. Activities can occur in any of these areas. Joint activities were observed with dementia level care residents in the rest home lounge. Staff advised that residents from dementia unit are always escorted by a staff member. There is adequate space to allow maximum freedom of movement while promoting safety for those who may 'wander'. The furnishings and seating are appropriate for the resident group. Residents interviewed reported they were able to move around the facility with staff assisted them when required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The service has policies and procedures in place for effective management of laundry and cleaning. There is a designated area for the storage of cleaning and laundry chemicals and a sluice room for the disposal of soiled water or waste. The facility is cleaned by rostered cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. Bed linen is sent to a commercial laundry for processing and personal laundry is done on-site by caregivers. The laundry is small, but able to cater to the needs of rest home and dementia level residents. Caregivers interviewed described how they manage infectious items. Residents and relatives interviewed were satisfied with the laundry service. Laundry services audit showed 90 % compliance and identified corrective actions were completed.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency and disaster policies and procedures are in documented for the service. Fire evacuation drills take place every six months. The orientation programme and education and training programme includes fire training. Staff interviews confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. An approved fire evacuation plan is in place. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and the availability of a gas BBQ. A back-up battery for emergency lighting is in place. A call bell system is in place, suitable to meet the needs of the residents. During the audit call bells were observed in close proximity to residents. Residents reported their call bells are answered in a timely manner. There is a minimum of one person rostered on each shift with a current first aid/CPR certificate. External lighting is adequate for safety and security. Doors are locked at dusk and the dementia unit has secure access/egress.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal rooms have a window opening to the outside. All areas were warm and well ventilated. There is underfloor heating in the dementia unit plus radiators. Residents and family interviewed stated the environment was warm and comfortable.
Standard 3.1: Infection control management 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.	FA	Woodlands has an established infection control programme; its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The clinical leader is the designated infection control nurse. The quality/staff meeting team is the infection control team, minutes from this meeting are available to all staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. There is ongoing training around infection prevention, Covid-19 precautions, and appropriate PPE use. Visitors are asked not to visit the facility if unwell. There are hand sanitisers placed throughout the facility. Residents and staff are offered the influenza and Covid-19 vaccine.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The clinical leader is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) have good external support from the local laboratory infection control team and DHB IC nurse specialist. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There are policies around Covid-19 and outbreak management. Policies and procedures are up-to-date, and staff are notified of any reviews/updates at staff meetings.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IC nurse is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training has occurred multiple times in 2021, this included Covid-19, hand washing, and PPE use training. The IC nurse has received training to enhance her skills and knowledge. She is also supported by the clinical leader from their sister facility, Woodlands Feilding. The infection control nurse has access to up-to-date information around infection prevention and control. On entry to service, Covid-19 health screening occurs, and visitor details are recorded. PPE and antibacterial gels are available, and staff and visitors are encouraged to use these as appropriate. Staff interviews confirmed ongoing training around hand washing, Covid -19, and infection prevention and control. Staff interviewed were knowledgeable around these subjects. PPE and emergency infection control stock were sighted, this was stored appropriately in quantities appropriate for the size and scope of the service.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance systems are appropriate to the size and complexity of the service. Monthly infection data is collected and collated for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review, and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, this is acted upon in a timely manner. Reports are easily accessible to all staff. Staff and the management advised that there have been no outbreaks in the last 10 years.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. At the time of the audit there were no residents with a restraint and one (rest home level) resident using bedrails as an enabler. This resident's file was reviewed. A restraint enabler assessment has been completed and the enabler is linked to the resident's care plan. Risks associated with the used of bedrails are identified. The resident provided written consent for the use of the bedrails. This resident was interviewed. The bedrails are assisting in keeping the resident safe in bed. Monitoring is in place, twice per shift. Staff training is in place around restraint minimisation and management of challenging behaviours (link 1.2.7.5).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The appointment of new staff includes the applicant completing an application, undergoing an interview and completing a police check. Missing was evidence of reference checking new applicants.	Four of five staff files reviewed indicated that reference checking had not occurred.	Ensure that reference checking is completed prior to the appointment of the applicant. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.