

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

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:	Homestead Ilam Care & Hospital Limited
Premises audited:	Homestead Ilam Care & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 November 2021 End date: 4 November 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:	36



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

Homestead Ilam Care & Hospital is privately owned since January 2021. The service provides rest home and hospital care for up to 39 residents. On the day of the audit there were 36 residents.

This certification audit was conducted against the relevant Health and Disability Services 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, staff, management, and general practitioner.

The owner is the manager (non-clinical). There is a clinical nurse manager who has been in the role for three years and is supported by a quality coordinator.

Residents, relatives, and the general practitioner interviewed all spoke positively about the care and support provided.

The service implements the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care is in place.

The service continues to make improvements to the environment and embed the new business philosophy and culture.

This audit identified improvements are required related to staff orientation, service delivery documentation and medication charts.

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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Staff at Homestead Ilam Care & Hospital strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication, and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Homestead Ilam Care & Hospital has a current business plan and a quality and risk management programme that outlines goals for the year. Meetings are held to discuss quality and risk management processes. An internal audit programme identifies corrective actions and areas for improvement which have been implemented. Residents'/family meetings are held regularly, and residents and families are surveyed annually.

Health and safety policies, systems and processes are implemented to manage risk. Incidents are collated monthly and reported at facility meetings. Falls prevention strategies are in place that includes the analysis of falls incidents.

There is an annual education and training programme in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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An admission package is provided to family and residents prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses are responsible for all aspects of care planning, assessment, and evaluation of care with the resident and/or family input. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital, and dementia care residents.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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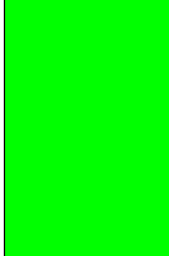
The building has a current building warrant of fitness and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in CPR and first aid is always on duty.

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 policies and procedures to ensure that restraint is a last resort. On the day of the audit there were no residents with any restraints and three residents using an enabler. Staff receive training in restraint minimisation and challenging behaviour.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme includes policies, standards, and procedures to guide staff. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (RN) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. A monthly infection control report is completed. There have been no outbreaks. A pandemic plan was actioned, and Covid-19 policies and procedures have been developed and implemented. Homestead Care & Hospital continues to implement current Covid-19 regulations around contact tracing.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	4	1	0	0
Criteria	0	88	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with eight clinical staff (six caregivers, one registered nurse [RN], and one diversional therapist) confirmed their familiarity with the Code. Interviews with seven residents (three rest home including two younger persons under 65 years and four hospital including one on palliative care) and one relative (hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff, and quality risk/health & safety meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advance directive instructions. Staff are aware of advance directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents identified that the service actively involves them in decision making.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur without restrictions when Covid-19 alert levels permits. Younger persons (LTS-CHC) interviewed stated they are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs, and interest groups in the community. Residents confirmed the staff help them access community groups. Residents informed that relatives and friends are encouraged to be involved with the service and care. Male residents are supported to attend the community Men's group. Two residents are being supported to attend regular home visits.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The manager and clinical nurse manager maintain a record of all complaints, both verbal and written. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>There were no complaints logged since the previous provisional audit in November 2020. The manager confirmed all complaints (when received) are documented, a comprehensive investigation, follow-up, and replies to the complainant.</p> <p>Staff interviewed could describe the procedure for directing complaints to the most senior person on duty. Discussions with residents and the relative confirmed they were provided with information on complaints and complaints forms. Complaint forms are available in the foyer. The policy is visible on the noticeboards beside the nurses' station.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the manager or clinical nurse manager discusses the information pack</p>

their rights.		with the resident and the family/whānau. The information pack includes a copy of the Code.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff receive training on abuse and neglect. Staff interviewed could describe how they ensure privacy is maintained.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is one resident of Maori descent and Maori staff. Cultural days and education around different cultures and cultural safety is held. The manager interviewed confirmed advice and guidance on cultural matters related to Māori is available from the local district health board Māori and Pasifika health. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural safety/awareness.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial,</p>	FA	The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction

or other exploitation.		includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>There is a quality programme that continuously identifies opportunities for improvement. Regular scheduled education sessions provide professional development and to upskill the workforce.</p> <p>Since change of ownership the new directors have worked to establish a culture/identity for the staff to feel a part of and the residents to take comfort in seeing existed. The new owners have created a new logo and brand name 'Homesteadcare Ilam' . This has been established and captures what they are all about which is: 'Kindness and Care is at the heart of what they do and their business goals. They introduced an Employee of the Month award which is where a staff member demonstrates their CARE pillars: Commitment, Atmosphere, Respect and Excellence. They have established a leadership team which meet every Monday morning to ensure everyone is up to date and it provides an opportunity for feedback. There have been several environmental improvements and refurbishments.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and a relative interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The manager and clinical nurse manager (RN) operate an open-door policy. Twelve incident/accident forms reviewed from October 2021 identified the next of kin (NOK) were notified following a resident incident. The clinical nurse manager, the registered nurse and caregivers confirmed relatives are kept informed. The relative interviewed confirmed they are notified promptly of any incidents/accidents. Interpreter services are available as required.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Homesteadcare Ilam provides care for up to 39 rest home and hospital level residents. Thirty-seven of thirty-nine beds are dual-purpose (two beds are rest home only). One room has been certified as a double room (Homestead wing), the manager reported this has only ever been used as a single room.</p> <p>On the days of audit there were 36 residents.</p> <p>On the day of the audit, there were five younger residents on a long-term support - chronic health contract (LTS-CHC), one on respite care at rest home level, and 13 residents at rest home level care on the age-</p>

		<p>related residential care contract (ARRC). There were 17 residents receiving hospital level care (ARRC) including one resident on an individual funding Ministry of Health contract and one on end-of-life contract (EOL).</p> <p>The 2021-2022 business plan has been documented to reflect the new business philosophy, mission, and vision. The 2021 quality plan is on schedule. Quality goals for the year include staff education, client-centred approach, and general refurbishments. Quality goals feature as an agenda item for the quality meeting and progress is documented in the meeting minutes.</p> <p>The facility is managed by a (non-clinical) owner. The manager has a background in investment banking and project management experience. He is supported by a full-time clinical nurse manager who has been employed in the role for three years. The clinical nurse manager was a registered nurse at the facility for ten years prior to moving into the clinical nurse manager role. The quality coordinator, a registered nurse, also worked at the facility as a registered nurse for eight years prior to becoming the quality coordinator four years ago. The quality coordinator currently works three days a week.</p> <p>Both the manager and the clinical nurse manager have attended at least eight hours education around the management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical nurse manager along with the quality coordinator, provide cover during a temporary absence of the manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service's policies are reviewed by an external contractor every two years, or sooner if required. Staff have access to policy manuals. The quality management system and performance monitoring programme continued from the previous year. The policies were reviewed in May 2021 by an external consultant to reflect the new business name and philosophy. Reviews of policies will occur two yearly.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys, and complaints management. Data is collected and entered onto the electronic system, analysed, and presented at the meetings by the quality coordinator. Where improvements are identified, corrective actions are developed, implemented, and regularly</p>

		<p>evaluated.</p> <p>The combined quality/health and safety/infection control meetings are held two-monthly. The quality team is representative of the facility. Meeting minutes evidenced quality data, trends and analysis including areas for improvement around infections, accidents and incidents, health and safety, restraints/enablers, concerns/complaints, internal audit outcomes and quality goals. Agenda items cover health and safety issues, new hazards, hazard register reviews, education, and concerns/issues from each department of the facility. Results of this meeting are discussed at the monthly staff meetings. The minutes of the staff meetings evidenced discussion around quality data and corrective actions.</p> <p>The satisfaction survey completed in November 2020 evidenced overall satisfaction with the service. Corrective actions were identified for areas of low satisfaction and were discussed at the combined quality meeting and staff meetings. As a result of comments related to the garden and outdoor areas, significant improvement had been done to improve the outdoor areas including new furniture. The food satisfaction survey for 2021 showed overall satisfaction with the meals, and residents provided suggestions around the types and variety of meals which have been incorporated into the menu. Satisfaction results were shared at staff and resident meetings.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual paper-based reports are completed for each incident/accident by the caregivers and registered nurses (first on the scene), with immediate action noted and any follow-up action(s) required. The incident reports are reviewed and signed off by the quality coordinator (RN) and entered onto the electronic system. The data is analysed, and corrective actions to minimise risks are discussed at meetings.</p> <p>Twelve electronic resident related accident/incident forms were reviewed (eight hospital and four rest home level). Each event involving a resident reflected follow-up by a registered nurse. The next of kin had been informed (as requested by relatives). Neurological observations are conducted for suspected head injuries, and where possible identify opportunities to minimise, future risks were identified and implemented.</p> <p>The management team are aware of their requirement to notify relevant authorities in relation to essential notifications. One section 31 notification was made on the day of the audit to indicate RN unavailability in October 2021 (twelve RN shifts covered by either the clinical nurse manager or quality coordinator). There were no other section 31 notifications since the last audit. There have been no outbreaks since the previous audit in November 2020.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>Seven staff files were reviewed (three RNs, three caregivers, and one cook); orientation documentation is kept on file however four new staff orientation documentation had not been completed as required .</p> <p>Files evidenced implementation of the recruitment process, employment contracts, house rules and annual performance appraisals.</p> <p>A register of practising certificates was sighted. A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: medications, restraint, infection control and hand washing, hoists, and manual handling).</p> <p>There is an annual education and training schedule being implemented. The caregivers are encouraged to undertake a New Zealand Qualification Authority (NZQA) qualification (Careerforce). Currently, all 19 caregivers have qualifications, nine caregivers with level 4 NZQA, five with level 3 and five with level 2.</p> <p>Registered nurses are provided opportunities for training from the DHB and attend external first aid and syringe driver training, all first aid certificates were current.</p> <p>The clinical nurse manager and registered nurses are able to attend external training such as seminars and education sessions with the local DHB. Four of the current five RNs including the quality coordinator are trained in interRAI.</p> <p>On the day of the audit a new registered nurse commenced orientation. The service continues to rely on agency availability to replace the sick leave and annual leave.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There were three registered nurses that resigned this year, however, the manager and clinical nurse manager reported they now have a full complement of registered nurses, with the most recently employed registered nurse due to commence orientation at the beginning of October 2021. Agency staff have been utilised to cover vacant RN shifts, however due to leave/sickness, the clinical nurse manager was covering the weekend night shifts on occasions. Management reported all staff members will return to their regular positions once the new RN is orientated to the position.</p> <p>The manager, and clinical manager are full-time Monday to Friday. The quality coordinator (RN) works 8 am to 4.15 pm Monday, Wednesday and Thursday. There is one registered nurse on each shift and 1x</p>

		<p>6.45 am to 2 pm (senior caregiver with medication competency work across all wings).</p> <p>Kyle has 14 beds with 10 hospital level residents and three rest home residents.</p> <p>Morning shift has three caregivers: 1x 7 am to 3.15 pm, 2x 7 am to 1.30 pm</p> <p>Afternoon shift has two caregivers: 1x 3 pm to 11 pm and one from 4pm-8pm</p> <p>Ilam has 15 beds (one double room but single occupancy), with 11 rest home residents including five LTS-CHC and two hospital level residents. Residents are very independent in this unit.</p> <p>Morning shift has one caregiver: 1x 7 am to 3.15 pm and gets assistance from Homestead floater</p> <p>Afternoon shift has one caregiver from 4.30 pm to 11pm and gets assistance from Homestead floater</p> <p>Homestead has 11 beds with five hospital level residents and five rest home level residents including one respite resident.</p> <p>Morning shift has two caregivers: 1x 7 am to 3.15 pm, and 1x 7 am to 1.30 pm (floater)</p> <p>Afternoon shift has two caregivers: 1x 3 pm to 8.30 pm, and 1x 4.30 pm to 8.30 pm (floater).</p> <p>The pm caregivers from Kyle and Ilam the facility cover from 8.30 pm to 11 pm</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files were located in the nurses' station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has</p>	<p>FA</p>	<p>All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and includes associated information such as the Code of Rights, advocacy, and the complaints procedure.</p> <p>Comprehensive information is available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p>

been identified.		Six signed admission agreements were sighted. The admission agreement reviewed aligns with the ARC contract. Exclusions from the service are included in the admission agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service. The yellow envelope system is used for transfers to hospital.
<p>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>	PA Moderate	<p>Medicine management policies and procedures that meet legislative requirements are in place and implemented. The RNs and senior caregivers who administer medications complete annual medication competencies and education on medication is provided. All medication is stored in a locked cupboard in the central nurses' station or in the treatment room. Fridge and air temperatures met requirements. An RN does a weekly check for expired medication. Unwanted or expired medications are collected by the pharmacy weekly. Medicines (robotic rolls) are delivered weekly by the pharmacy, checked by an RN on-site, verified on the electronic medication system. Any discrepancies are fed back to the pharmacy. Standing orders are not used. All eye drops were noted to be dated at opening. A bulk supply of minimal stock medicines was available in the hospital.</p> <p>A medication round was observed; the procedure followed by the registered nurse was correct and safe. The service uses an electronic medication administration system.</p> <p>Twelve individual resident's medication charts were reviewed. Resident medication charts are identified with photographs. All charts had been correctly signed and all discontinued medications had been signed and dated. All PRN medications included indication for use and the effectiveness of 'as required' medications was documented in the electronic medication system. There was evidence of three-monthly review by the GP. Allergies were not all documented for all residents.</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</p>	FA	The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. All meals at the service are prepared and cooked on site. The cook is supported by a second cook and a morning and afternoon kitchenhand. Meals are prepared in a well-appointed kitchen adjacent to the main dining room and served directly to the residents. A nearby activities room is used for residents requiring assistance at mealtimes. Staff were observed delivering meals and assisting residents with their lunchtime meals as required.

<p>component of service delivery.</p>		<p>The five-weekly seasonal menu has been reviewed by a registered dietitian in April 2021 as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs, allergies, cultural and religious preferences, likes, and dislikes have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. A dietary requirement list is updated with new admissions and changes and posted beside the servery.</p> <p>A kitchen cleaning schedule was in place and implemented. Labels and dates on all containers and records of food temperature monitoring were maintained. The chiller, fridge and freezer temperatures were monitored. The kitchen was observed to be clean and well organised. All aspects of food procurement, production, preparation, storage, delivery, and disposal complied with current legislation and guidelines.</p> <p>Kitchen staff are trained in safe food handling, and food safety procedures were adhered to. The food control plan expires in April 2022.</p> <p>Resident weekly meetings and surveys provide an opportunity for resident feedback on the meals and food services. A specific food satisfaction survey was distributed in October and results are pending. Interviews with residents and a family member indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents to the service is recorded. Should this occur, the service stated it would be communicated to the potential resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>An RN completes an initial assessment and care plan on admission, including a range of paper-based clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly. The interRAI assessment is completed in files reviewed (link 1.3.3.3). The outcomes of assessments form the basis of the long-term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	<p>PA Low</p>	<p>Six resident files sampled all included a care plan and demonstrated service integration and input from allied health. There was evidence of resident (where able) and family consultation in the care planning</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>process. Short-term care plans were in use for changes in health status. Resident care plans reviewed were resident-centred, however did not always document the required support needs in sufficient detail. Obsolete interventions had not always been crossed out. Residents with challenging behaviours had triggers (where they could be identified), a description of behaviour, and individualised de-escalation techniques documented. Activities assessments and plans were in place for all resident files reviewed.</p> <p>Care plans reviewed demonstrated service integration and input from allied health. InterRAI assessments have not always informed the care plans in a timely manner (link 1.3.3.3) and care plans do not always reflect the required support needs. There was evidence of service integration with documented input from a range of specialist care professionals, including, Nurse Maude specialists, mental health services for older people, physiotherapy, and podiatry support. Assessments and care plans reviewed included input from allied health professionals. The residents and relative interviewed confirmed they were happy with the delivery of care. Caregivers interviewed reported they found the care plans easy to follow and contain information to provide quality care for residents.</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>Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions were documented for each goal in the long-term care plans. Interventions from allied health providers were included in the long-term and short-term care plans.</p> <p>Dressing supplies and continence products are readily available. There are sufficient stocks of PPE to meet requirements. If external allied health requests or referrals are required, the clinical nurse manager initiates the referral (e.g., wound care specialist, dietitian, or mental health team). A physiotherapist visits weekly and reviews new residents. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>Wound assessment and wound management plans were in place for eight residents with 11 wounds: one chronic ulcer, four skin tears, and one stage two, two stage one pressure injuries and two others. The pressure injuries are progressing towards healing. All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing except for the chronic ulcer. Short-term care plans for acute wound care had interventions around management of wounds and dressings.</p> <p>The residents' files included a urinary continence assessment, bowel management plan, and continence products used. There were adequate supplies of incontinence products. The clinical nurse manager interviewed confirmed continence advice can be obtained</p> <p>Short-term care plans are utilised to document short-term needs for resident changes to health. These had been reviewed in a timely manner or added to the long-term care plan.</p> <p>There was evidence of monitoring including positioning charts, monthly (or more frequent) weight and vital</p>

		<p>sign monitoring, catheter changes, blood glucose levels food and fluid charts and behaviour charts in place.</p> <p>The relatives interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</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>FA</p>	<p>The activity programme confirmed that independence was encouraged, and choices were offered to residents. The experienced diversional therapist works 35 hours a week and is providing a varied and innovative programme. The programme includes a range of activities which meets the abilities and needs of both hospital and rest home residents. Specific activities and community involvement is provided for younger residents.</p> <p>Activities included physical, mental, spiritual, and social aspects of life to improve and maintain residents' wellbeing. Activities included bus trips, walking groups, exercises, indoor sports, church group visits, community visits from church groups, schools, and preschools (depending on Covid-19 guidelines) and much more. An annual facility-wide trip to Akaroa for fish and chips is held. A music moves me programme by a music therapist involves but is not limited to bongo drums and microphone singing. One-on-one time is spent with residents prior to the start of the programme at 10:30 am. Individual activities such as walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. Younger residents are encouraged to maintain links with the community with support to manage public transport and attend church groups. Younger residents are also very involved with the facility garden and local university walks.</p> <p>There are volunteers involved in the programme, including an art therapist, who runs art classes, a music therapist for music therapy, which the DT reported is especially beneficial for residents with memory loss. Pet therapy is provided according to Covid-19 guidelines, and gardening is available for residents.</p> <p>On admission, an activity coordinator completes a profile for each resident within three days and an activity plan is completed within three weeks. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Covid-19 risk management strategies has meant continuing periods of reduced access for visitors to the facility. Regular facetime and zoom sessions were held with families at these times.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Feedback from the residents is gained through annual surveys, monthly meetings and a resident debrief session weekly where the activities coordinator receives feedback on specific activity sessions and ideas for the following week.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Registered nurses evaluate initial care plans. Files sampled demonstrated that the long-term nursing care plan was not always evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Evaluations reviewed do not always document progress toward goals. An RN signs care plan reviews. Changes to resident health status is not always updated in the care plans (link 1.3.5.2). Residents (where appropriate) and the relative interviewed stated they were involved in care planning reviews or were informed of changes made.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The GP and RN involve the resident (as appropriate) and relative in discussions around referrals and options for care. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemicals are stored in a locked cupboard. Additional chemical stocks are secured in an external building. Chemical bottles sighted have correct manufacturer labels. A sluice tub is located within the laundry. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. All staff have completed chemical safety training in June 2021.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The building has a current building warrant of fitness that expires 1 June 2022. The maintenance person was interviewed and works four hours a day Monday to Friday. He completes maintenance requests and repairs, planned maintenance and gardens and grounds. Staff complete yellow forms for requests for</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>repairs. A record is maintained of all repairs which is signed off by the maintenance person. There is a 52-week planned maintenance schedule in place and all maintenance undertaken is monitored by the manager with the assistance of the quality coordinator. Planned maintenance includes interior and exterior building, equipment checks, electrical checks and hot water temperature checks. Essential contractors are available 24 hours. There is ongoing refurbishment of resident rooms including mirrored bathroom cabinets, furniture, artwork and lighting, toilets and showers and communal areas including replacement of furnishings and equipment. New furniture, additional painting, and remodelling and renovation of the entrance have contributed to an open warm and inviting environment. Additional parking has been created following removal of excess vegetation and a neighbouring derelict building.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe ramp access to courtyards and garden areas. Outdoor areas have wrap-around established gardens. Seating and shade are provided.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs, chair scales, hoists, and pressure injury resources (if required), to safely deliver the cares as outlined in the residents' care plans. Residents commented positively on the environmental improvements made under the new ownership.</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>	<p>FA</p>	<p>All resident rooms have toilet ensuite facilities. Six of the rooms in Homestead wing have full ensuite facilities. There are adequate numbers of shared showers in each wing for residents to use. The shared facilities have signs to indicate if the shower is being used. Privacy curtains are in place in the shower rooms and the resident ensuites. Residents confirmed staff respect their privacy while attending to their care. All shower areas have been renovated and comply with health and safety and infection control standards.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	<p>FA</p>	<p>All rooms currently have single occupancy. There is one certified double room in the Homestead wing. Thirty-seven of thirty-nine rooms are certified as dual purpose. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms. Rooms viewed were personalised with residents own furnishings and adornments as viewed on the day of audit. Resident rooms have large windows with lovely views of the gardens.</p>

consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large communal lounge and dining area that is well used and several smaller areas including a library area. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The main lounge is used for activities. There is a specific area for the hairdresser in a shower room. The outdoor courtyards are also used for activities during the summer.</p> <p>The corridors have been painted throughout the facility. Flooring has been replaced and the activities room has been renovated. There is a smoking area for residents outside of the building.</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>All laundry is completed in site. The laundry has a defined clean/dirty area. Linen and personal clothing is delivered to the laundry in covered buckets where it is sorted. Residents and a relative expressed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. Chemicals are labelled. Material safety data sheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. There is protective personal clothing including eye goggles available. Laundry staff have completed chemical safety training.</p> <p>Cleaning schedules had been updated to include Covid-19 prevention strategies and include cleaning of equipment, touch screens, stationary between uses.</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>	FA	<p>Emergency, disaster policies and procedures are documented for the service. There is an approved fire evacuation scheme. Fire drills occur every six months (last fire drill occurred in March 2021 and next booked for 15 November 2021). Education around fire and emergency responses was held in September 2021. The orientation programme and annual education/training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. First aid training is completed by registered nurses. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food and water supplies to last for three days, and blankets are available for residents. A gas BBQ and gas hobs in the kitchen are available for alternate cooking, and a generator can be accessed. Emergency lighting is in place. A call bell system is in place including all resident rooms and communal areas. Call bell audits are completed monthly. Residents were observed in their rooms with their call bell alarms in proximity.</p> <p>The facility is secure at night with facility checks completed by the afternoon and night staff.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light. There is radiator heating and a heat pump in the corridors in Homestead wing, with ceiling heaters in the rest of the building and resident rooms. There is a heat pump in the dining room.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The quality coordinator (RN) is the infection control coordinator and has a defined job description that outlines the role and responsibilities. The infection control team (quality team, representative of the facility) report bi-monthly at the combined quality/health and safety and infection control meeting. The IC programme is appropriate for the size and complexity of the service. Infection control is discussed at the daily handovers with staff to include ongoing and new infections and interventions and to alert staff to the short-term care plans. Graphs of statistics and the quality meeting minutes are available to staff in a folder at the nurses' station.</p> <p>There are adequate hand sanitisers placed throughout the facility. Adequate stocks of personal protective equipment were sighted. There is an implemented Covid-19 management plan according to alert level guidelines that include QR code contact tracing. A visiting protocol is in place to ensure visitors are well and free from exposure to illness.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for infection control with support from the clinical manager. The infection control coordinator has attended external education in the last year. The infection control coordinator has access to infection control personnel within the district health board, infection control specialist, laboratory services and the GP.</p> <p>Covid-19: A resource folder was maintained with all current information and guidelines to follow for each level of lockdown. The quality coordinator has developed a file with specific instructions and signage to use for the stages of lockdown for staff to utilise in the event of changes in levels. All screening was adhered to, and records maintained. The service has been compliant with guidelines and documentation requirements throughout the period. All visitors are required to complete a wellness declaration and use the hand gel when signing into the facility. Staff, residents, and visitors are required to wear masks. The staff and residents have received Covid-19 and flu vaccinations. Staff were observed to adhere to good handwashing practices.</p> <p>The residents and relative interviewed felt they were updated regularly and were complimentary of the way</p>

		the management and staff dealt with the lockdown at different levels. All stocks of personal protective equipment and outbreak equipment required is held centrally in the facility.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Homestead 's infection control policies and an electronic and hard copy infection control manual obtained through an external provider (HCSL), which reflect current practise and have been regularly reviewed. Policy, procedures, and the pandemic plan have been updated to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>All new staff receive infection control education at orientation, including hand washing and an infection control questionnaire. Infection control education is included in the annual education planner. Education was held around donning and doffing personal protective equipment, handwashing, and outbreak management in April 2021.</p> <p>There is an infection control folder and a Covid-19 chart in the nurse's station for quick reference for any infection control events. Resident education occurs as part of care delivery.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection monitoring is the responsibility of the IC coordinator (the quality manager). All infections are entered into the electronic database, which generates a monthly analysis of the data and includes benchmarking against other similar services. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There is monthly, three monthly and annual seasonal comparison of infection events. Outcomes are discussed at the combined quality/infection control/health and safety meetings, registered nurse, and daily handovers. The GPs also monitor and review the use of antibiotics. There has been a low incidence of infection since the previous audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. The clinical nurse manager is the restraint coordinator and has a job description in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually (last held in August 2021). Caregivers interviewed could describe the differences between restraint and enablers and procedures around these. Restraint competencies are completed annually.</p> <p>No residents were using restraint and three residents were using enablers (lap belts, tray table and bedrails in use). All residents had consent forms in place which has been signed by the resident and the GP. Assessments (including risks) and care plans were in place and reviewed three- monthly. Monitoring forms have been maintained as instructed in the care plans.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>There is a documented orientation policy including the key aspects of the orientation programme. The policy required orientation documentation to be signed off by the supervisor, manager of 'buddy.' Caregivers interviewed confirmed the orientation of new staff is adequate to provide the skills needed to perform their duties.</p>	<p>(i) Three staff (cook and two caregivers) have not signed off all the key components in their orientation documentation.</p> <p>(ii) One RN had completed orientation and signed all key components, however this occurred six months after commencement of employment.</p>	<p>(i) Ensure all key components of the orientation is completed and signed off.</p> <p>(ii) Ensure orientation documentation is completed within a timely manner.</p> <p>90 days</p>

<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>	<p>PA Moderate</p>	<p>Twelve individual resident's medication charts were reviewed. Resident medication charts are identified with photographs. All charts had been correctly signed and all discontinued medications had been signed and dated. All PRN medications included indication for use and the effectiveness of 'as required' medications was documented in the electronic medication system. Medication charts reviewed. Allergies were not all documented for all residents.</p>	<p>Three of twelve medication charts reviewed did not have the allergy status documented.</p>	<p>Ensure all residents files document the residents' allergy status.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Risk assessments are completed on admission including a clinical risk assessment (which identifies risks associated with medical history). Information from the assessments has been included in the care plans, however, not all interRAI reassessments have been completed within timeframes. There are four interRAI trained RNs including the quality coordinator. As a result of RN shortages, the clinical nurse manager and quality coordinator have worked on the floor and as a result, interRAI and long-term care plan evaluations have not always been completed within expected timeframes.</p>	<p>(i) InterRAI reassessments were not completed within timeframes for one rest home and three long-term hospital files reviewed.</p> <p>(ii) Long-term care plans had not been evaluated in line with interRAI assessments for two hospital residents.</p> <p>(iii) Long term care plans had not been evaluated six-monthly for two hospital residents.</p>	<p>(i) - (ii) Ensure interRAI reassessments are completed within expected timeframes and correspond with care plan evaluations.</p> <p>(iii) Ensure long term care plans are evaluated six-monthly.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required</p>	<p>PA Low</p>	<p>The RNs are responsible for all resident assessment and care planning. All residents had a care plan documented. The interventions documented did not reflect all resident current needs. Caregivers</p>	<p>Two of six care plans had not been updated to reflect care needs and/or did not reflect individualised care</p>	<p>Ensure that care plans document the individualised</p>

<p>support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>interviewed, were knowledgeable regarding resident needs.</p>	<p>needs. This included:</p> <p>(i) One resident file documented care of IV antibiotic infusions, however this had been discontinued. The same resident did not have the risks of treatment associated with diabetes, blood glucose testing and insulin in their care plan. The care plan referred to care of a surgical implant which had been removed. The care plan did not fully reflect the changes in mobility and the aids required.</p> <p>(ii) One resident had weight loss, however interventions to manage this were not documented in the care plan.</p>	<p>care needs for each resident.</p> <p>90 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Evaluations are documented following care plan reviews and multi-disciplinary meetings.</p>	<p>Evaluations did not reflect progress towards meeting goals in three of six files reviewed.</p>	<p>Ensure evaluations document progress towards meeting goals.</p> <p>90 days</p>

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.