

Edenvale Trust Board

Introduction

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

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Edenvale Trust Board
Premises audited:	Edenvale Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 September 2015 End date: 23 September 2015
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:	40

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

The Evendale Rest Home provides rest home, hospital and dementia care for up to 41 residents. There were 40 residents on the day of the audit. The service is managed by the general manager and governed by the Board of Trustees. There have been no changes to the organisation, or the services provided, since the last certification audit.

This certification audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The organisation has implemented a number of quality improvements. This has resulted in a continuous improvement rating. One low risk area of non-conformance has also been identified.

Consumer rights

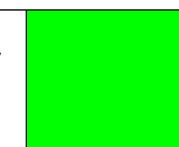
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	Green	Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. Residents and family members confirmed their rights are being met. Written consents and agreements are gained as required.

Services are delivered in a manner that respects the independence, personal privacy, individual needs and dignity of residents. Policies are in place to ensure residents are free from discrimination and abuse and neglect.

Complaints information complied with requirements and is readily available to residents. A complaints register has been 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.		Standards applicable to this service fully attained.
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The scope, direction and objectives of the service are defined and monitored through the reporting process. The general manager is suitably qualified to perform the role.

Quality and risk management systems are defined and quality activities are monitored. Quality initiatives are implemented and improvements made in an ongoing manner. Organisational, operational and clinical risks are identified and monitored. The adverse events process ensures opportunities for improvement are responded to.

Policies and procedures provide staff with work instructions and guidelines based on best practice, standards, contracts and legislation.

The human resource management system ensures residents are supported by suitable and competent staff. Staffing and rostering processes ensure there were sufficient numbers of trained staff on site at all times.

Resident records are managed in a manner that provides 'real time' reporting. All records are secure and include the required information.

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 low risk.</p>
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Residents receive timely, competent and appropriate services that meet their assessed needs and desired outcome/goals. The residents are admitted with the use of standardised risk assessment tools. Short term care plans are consistently developed when acute conditions are identified. The long term care plans are reviewed every six months. Planned activities are appropriate to the needs, age and culture of the residents. Meal services meet the individual food, fluids and nutritional needs of the residents.

All medication charts are reviewed by the general practitioner every three months. There are no expired or unwanted medications. The controlled drug register is current and correct. One improvement is required regarding training and competencies when crushing medication.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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All building and plant comply with legislation. A preventative and reactive maintenance programme was evident.

Residents' bedrooms are suitable to their needs. This includes a secure area for residents with dementia. A number of lounges, dining areas and communal areas are available. External areas are accessible and safe.

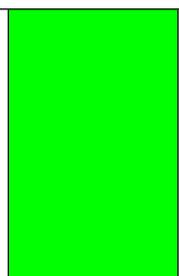
An appropriate call bell system and security system is in place. Protective equipment and clothing is provided. Chemicals, linen and equipment are safely stored and there are sufficient supplies and resources to manage emergency situations.

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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There are clear and comprehensive policies and procedures that meet the requirements of the restraint minimisation and safe practice. Risk management plans are in place when residents are using restraints. There is a restraint approval committee. All staff receive training on the use of restraints and enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff. In-service education is provided regularly. The type of surveillance is appropriate to the size and complexity of the service. Infection rate data is collected, recorded, analysed and reported. Recommendations to reduce infection rates are discussed during staff meetings.

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	49	0	1	0	0	0
Criteria	1	99	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff demonstrated knowledge and understanding of patient rights. Staff were able to verbalise how they ensured residents' rights were acknowledged and respected. Staff training on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is mandatory. In interview, residents reported their rights were explained, acknowledged and respected. Information on resident rights is given on entry. Compliance with the Code is measured through resident satisfaction surveys, internal audits and resident 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 informed consent policy guides staff regarding informed consent procedures. There was evidence of formal, documented consent relating to general consents with the addition of consents obtained on an as-required basis, such as for 'flu' vaccinations.</p> <p>There was also evidence of resuscitation and advanced directives. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p> <p>Evidence of enduring power of attorney (EPOA) was sighted, and the related policy included</p>

		competency requirements and activation of EPOA's.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy is included in the staff orientation programme and in the ongoing education programme for staff. Staff demonstrated their understanding of the advocacy service, with contact details for advocacy services readily available. Residents are provided with information on advocacy services as part of the admission process. Residents and family members confirmed their awareness of advocacy services and how to access this.
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 are encouraged to maintain their community interests and networks, and to visit with their families. The activities programme includes regular outings in and participation in community events. Community groups and entertainers also visited the facility on a regular basis. The service welcomes visitors, and had unrestricted visiting hours. Family members advised they felt welcome when they came to visit. Residents reported they were supported by staff to access health care services of their choice outside of the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The general manager (GM) is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register was maintained and confirmed that complaints were managed in an appropriate and timely manner. Quality and staff meeting minutes provided evidence of reporting of complaints to staff and that complaints are viewed as opportunities for improvement. Systems are in place to ensure residents and their family are advised of the complaint processes and the Code. Related policies meet the requirements of the Code and residents demonstrated an understanding and awareness of these processes. Information on the complaints process was readily available. There have been no complaints or investigations by the Ministry of Health, Health and Disability Commissioner, DHB and Accident Compensation Corporation (ACC) since the previous audit.
Standard 1.1.2: Consumer Rights During	FA	A copy of the Code and national advocacy services is given on first contact and displayed

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>throughout the facility. Residents reported they were given ample opportunities to discuss their concerns and questions. Residents and family members were familiar with the Code and advocacy services. None of those interviewed had concerns about any aspect of the services being provided. All those interviewed stated they would feel comfortable raising issues with any staff member.</p>
<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>	<p>FA</p>	<p>Resident privacy is respected and maintained. Staff receive training the on the code of conduct and professional boundaries. The abuse and neglect policy provides definitions and signs and symptoms of abuse and neglect. There are sufficient areas throughout the facility for residents to have private conversations. Maintaining privacy, dignity and respect is a mandatory training requirement.</p> <p>Specific needs such as cultural, religious or spiritual needs are identified during the admission and assessment process. In interview, residents and family members reported that their needs were met, privacy was maintained and that they were treated with dignity and respect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Cultural policies make reference to the Treaty of Waitangi, admission assessment, care planning, whanau support, Maori models of health, staff education and specific practices. Ethnic needs are identified during the pre-admission process. There are well documented processes in place to support residents who identify as Maori. Cultural safety is also a mandatory training topic.</p> <p>The business plan addresses barriers to access. The service has access to a Maori health advisor whom is from the Brethren Church. In interview, the general manager reported that tangata whenua are consulted and provided valuable support and resources, when required.</p>
<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>	<p>FA</p>	<p>A cultural assessment is included in the assessment process. Individual preferences, including values and beliefs of residents were included in the care plans reviewed. These plans included detailed interventions to ensure resident's individual requirements were accommodated. Residents and family members advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members stated that residents were free from discrimination or exploitation. The general manager advised that the orientation for new staff includes education related to all forms of discrimination and exploitation. Information on this topic is also included in each staff member's employment contract. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has established professional networks to help ensure residents received services of an appropriate standard, including specialist services at the local district health board (DHB). Clinical procedures are available to guide staff in all areas of service delivery. Registered nurses are also supported to attend external education sessions. The general practitioner confirmed that good practice was maintained with regard to clinical interventions and residents confirmed they had access to the care and support they required. Staff confirmed they had access to the required supplies and equipment.</p> <p>Recent quality improvements which support good practice include the monthly case reviews, peer supervision and clinical audits completed by the registered nurses, implementation of a nurse call system, the use of tablets for 'real time' reporting and implementation of an electronic medication management system.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members reported they had received clear and comprehensive information and were given sufficient time to consider the information provided. Staff reported that interpreter services could be accessed by a local provider if required. Staff are identified by uniforms and name badges.</p> <p>Residents and/or family representatives sign an admission agreement on entry. Edenvale Rest Home uses the New Zealand Aged Care Association Resident Agreement. This provides all new residents with sufficient information, including services provided as part of the agreement.</p> <p>Information is shared during family meetings which are conducted six weeks after admission. Family confirmed good communication with staff and management, as did the general practitioner. There was evidence of open disclosure following adverse events and family contacts are documented in progress notes.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The rest home is owned by a charitable trust and governed by a board of trustees. Strategic planning is conducted by the board and includes the requirements of the charities act, board membership and on-going development of services. The purpose and aim of the trust board is based on Christian principles. Organisational performance is monitored through a range of management reports. The GM has the required skills and experience with a background in business ownership and management. The GM has been working in the health sector for over 20 years and maintains skills/interest through attendance at relevant conferences and attendance at district health board (DHB) management training.</p> <p>The GM has the designated authority to make day to day decisions regarding service planning, financial management and human resources. The required financial protocols are documents. The GM attends board meetings and provides the board with monthly reports.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The administrator performs the manager's role during a temporary absence, with clinical coverage conducted by the clinical manager. Management responsibilities are documented. The organisational chart defines the flow of accountability and reporting throughout the organisation.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a quality and risk management system which includes a quality plan and a business plan. Both have clear quality goals. The business plans includes the purpose and objectives. This includes goals and methods for monitoring compliance. Achievement towards quality and business goals is monitored. Key components of service delivery are monitored through the collation of quality data and reviewed by the quality and risk monitoring group. Monthly staff meetings also included key components of service delivery, including quality and risk issues. Quality data is compared and analysed against previous results to make sure services are being delivered to an expected standard.</p> <p>Policies and procedures are aligned with current good practice and meet the legislative/contractual requirements. Policies and procedures are reviewed every second year, or changed sooner if required. Policies and procedures are controlled and current. Obsolete documents are removed from circulation. Staff confirmed they were alerted of changes in processes and consulted where relevant.</p> <p>An internal audit programme is fully implemented. The programme had been reviewed and</p>

		<p>improved in the last 12 months. This has resulted in a continuous improvement rating (refer criterion 1.2.3.7). Deficits identified via the internal audit process or adverse event process is used as opportunities to improve practice.</p> <p>Actual and potential risks are identified in the business plan and the service has an up to date hazard register. All risks were reviewed annually by management and the trustees. Documents sighted confirmed that the required risk management strategies were in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The organisation's obligations related to essential notification reporting was understood and implemented. All adverse, unplanned, or untoward events are reported and recorded. Family/whānau are notified. This is monitored by the clinical leader and the health and safety officer.</p> <p>Incidents are collated in year to date. Information is used to identify any shortfalls in service delivery and seen as an opportunity to improve services or identify risks. Incident and accident monthly reports are generated. This included specific data related to falls with and without injury, aggression, abuse, 'wandering' and medication errors. This data informed the quality report and was benchmarked against previously collected data. Any areas identified for improvement are written up as corrective actions.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management processes meet legislative and good practice requirements. Staff are employed to undertake roles appropriate to their skills and knowledge. Reference, credential and police checks are completed for all newly appointed staff. Practising certificates were validated for all health professionals.</p> <p>Staff orientation/induction processes are undertaken to enable staff to meet the needs of residents. Only staff that have recognised dementia care qualifications work within the secure dementia care area.</p> <p>There is a process to identify training requirements for staff with a clearly documented ongoing education plan and regular review of staff competencies. Education includes first aid, education related to aged care and specialised dementia care, emergency management, and all aspects of day to day management of residents. Training is implemented using a module system which had been developed by the GM. There are six mandatory modules. Nursing staff reported they also had access to off-site education. The medication competency programme requires extending to include the management of crushed medications (refer to criterion 1.3.12.3).</p>

		Staff performance is monitored. Current performance appraisals were sighted in all staff records sampled.
<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>	FA	<p>Residents receive timely, appropriate and safe service from suitably qualified, experienced service providers. Clinical services are overseen by a clinical leader (registered nurse). All shifts had a staff member who holds a current first aid certificate and a registered nurse (RN). Staffing levels and skill mix are maintained to meet contractual requirements as set out in policy. If the work load increased, owing to issues such as end of life care, staff and management confirmed additional staff are scheduled on duty. In interview, the GM reported that in the rare event bureau staff are used, they receive a full handover from the RN.</p> <p>A quality initiative regarding case management had been introduced in the last 12 months. Nurses are required to manage their own case load for 10 residents each. The role of case management includes ensuring care plans were current, setting up nurse aids daily tasks and monitoring that all residents' requirements and compliance requirements were being met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident related information is kept in both hard-copy and electronic files. Files were maintained securely. The rest home uses an electronic client management system and all staff enter their records through the use of tablets. This quality initiative has enabled 'real time' reporting and the GM can access certain reports for audit purposes. Electronic files are password protected and can only be accessed by designated staff. Archived material was also kept securely but was easily retrievable.</p> <p>Resident records include a unique identifier. Clinical records are well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes requirements and procedures to be followed when a resident is admitted. Signed admission agreements were sighted in residents' records. Residents and family reported that the admission agreement was discussed with them in detail. The welcome pack contains information about the service.</p> <p>All residents have needs assessments prior to admission to the service. The manager ensured that residents are accepted as per contractual requirements. All enquiries are recorded in the enquiry register.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The standard transfer notification form from the district health board is utilised when residents are required to be transferred to the public hospital or to another service. The RN confirmed that telephone handovers were conducted for all transfers to other services. Resident and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>All medications are reviewed regularly. Discontinued medications are signed and dated by the GP, allergies are documented in sufficient and photos were present. Prescriptions were written legibly. RNs conduct medication reconciliation on admission or when a resident was discharged back to the facility.</p> <p>Staff were noted crushing some medications during the observed medication rounds. Crushing medications was not included in the annual medication competencies.</p> <p>There were no expired or unwanted medications. Expired medications were returned to the pharmacy in a timely manner. The controlled drugs register is current and correct. Weekly stock takes are conducted by the RNs. All medications are stored appropriately.</p> <p>There were no residents who self-administered their medications. The self-administration policies and procedures are in place.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. All meals are prepared and cooked onsite by an independent food service contractor. The chef and the kitchen assistants have current food handling certificates.</p> <p>The chef had reported that the main meals were served at dinner time. The residents are provided with meals that meet their food, fluids and nutritional needs. The RNs complete the dietary requirement forms on admission and have provided a copy to the kitchen. The chef updates the kitchen board regularly. Additional or modified foods are also provided by the service.</p> <p>Fridge and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the rest home/hospital dining areas while meals are transported to the dementia unit. The meals are well presented and residents confirmed that they are provided with alternative meals as per requested. All residents are weighed regularly. Residents with weigh</p>

		loss problems are provided with food supplements.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	There is a documented policy on decline of entry to the service. When a resident's entry to the service was declined, the resident was referred back to the referrer to ensure that the resident will be admitted to the appropriate service provider. This was evident in the declined residents register. The registered nurse (RN) reported that the district health board needs assessors and social workers contact the manager to discuss the suitability of the resident prior sending the resident's family to view the facility.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The registered nurses utilise standardised risk assessment tools on admission. Assessment information are utilised in developing the resident's profile (initial plan of care) and the long term care plans. There was evidence in residents' files that assessments were conducted within the specified timeframes. The clinical leader has completed the InterRAI training. At the time of the audit there were no residents' requiring InterRAI to be conducted.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long term care plans are resident-focused and have evidence of input from other members of the health team. Continuity of service delivery is promoted. Goals are specific and measurable while the interventions are sufficiently detailed to address the desired goals/outcomes identified during the assessment process. Long term care plans are reviewed and updated in a timely manner. The RNs develop short term care plans for acute conditions. Residents and families confirmed they were involved in the development of long term care plans. Staff members are informed about changes in the care plans through the hand overs and staff meetings.</p> <p>Long term care plans in the dementia unit include sufficient detail to best manage the residents' behaviour over the 24 hour period. These include triggers, special instructions and diversional techniques.</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>	FA	Interventions were sufficiently detailed to address the assessed needs and desired goals/outcomes. The interventions in managing acute infections are documented in the short term care plans. Interventions are changed when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory.

<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>	FA	<p>Activities are appropriate to the needs, age and culture of the residents. Activities are physically and mentally stimulating. The activities officer develops the yearly activity plans with the manager and the residents. The weekly activities were posted in the main lounge. The rest home and dementia unit residents have different activity programmes with the dementia unit having more one-on-one sessions. All reviewed residents' files had well-documented activity plans that reflected the resident's preferred activities and interest. The resident's activities participation log was sighted. The activities in the dementia unit were overseen by the activities officer who had completed an equivalent training in dementia care. Residents and families confirmed that the activities provided were adequate and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Short term care plans are evaluated by the registered nurses and resolutions of identified acute conditions are documented. Long term care plans are reviewed and evaluated every six months or earlier as required. Interventions in both long term and short term care plans are modified when the outcomes were different from expected. Residents and family members have reported that they were involved in all aspects of care and reviews/evaluations. Staff members were involved in the review process via the annual multi-disciplinary reviews.</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>There are documented policies and procedures in relation to exit, transfer or transition of residents. The service utilises a standard referral form when referring residents to other service providers. There was evidence of referrals by the GP to other specialist services. Resident and the families are kept informed of the referrals made by the service. Internal referrals were facilitated by the clinical leader or by the RN's.</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>Material safety data sheets are available and accessible for staff. Education on chemical safety is provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>The hazard register includes a list of hazardous substances, and the appropriate emergency procedures. There are also policies on sharps management and cleaning decontamination of body fluids and waste. Hazardous substances were correctly labelled and all chemicals were securely stored. Protective clothing and equipment is provided and being used by staff.</p>

		Domestic rubbish is removed as per the rubbish removal procedure. Gas bottles are securely stored and checked annually.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Plant and equipment are fit for purpose. There is a current building warrant of fitness. There is a proactive and reactive maintenance programme. The testing and tagging of equipment and calibration of bio medical equipment was current. Staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use equipment.</p> <p>Some areas of the facility were currently undergoing further refurbishments including bedroom renovations to include wide doors and accessible bathrooms. Fire doors have also been widened.</p> <p>The external environment was appropriate to the range of activities undertaken in these areas. Residents are protected from risks associated with being outside. This includes a secure external area for the residents with dementia.</p> <p>Residents confirmed they knew the process to follow if any repairs/maintenance were required and that requests are appropriately actioned. Those able to do so confirmed they were able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of accessible showers, toilets and hand basins for residents. There is a combination of en-suites and shared toilets/bathrooms. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly.</p> <p>Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms are sufficient in size to provide personal space for residents, and allow staff and equipment to move around safely, with wide doors. There are 12 beds in the secure dementia area and all 29 beds throughout the rest home can be used for either rest home or hospital level care. On the day of the audit there were 11 residents in the dementia unit, 15 assessed as</p>

		requiring rest home level care and 14 residents requiring hospital level care.
<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>Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.</p> <p>The entire facility and grounds are secure with safe fencing. Some bedrooms also have secure courtyards. There are safe outdoor areas for residents with dementia.</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>Laundry and cleaning services are provided by external contractors. Only personal linen is washed on site. There is a designated laundry with dirty to clean flow provided. A laundry person is responsible for the management of personal laundry. The laundry person and the GM described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents. Staff cleaning and laundry policies and procedures are available. These include procedures for the safe storage and use of chemicals/poisons.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme.</p> <p>Residents and families confirmed they were satisfied with the cleaning and laundry service. This finding was confirmed during review of the satisfaction survey questionnaires.</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>Documented systems are in place for essential, emergency and security services. Policies and procedures identify provider/contractor identification requirements along with visitor identification. Information in relation to emergency and security situations are readily available/displayed. Emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There are sufficient resources in place in the event of a civil defence emergency. Emergency and security management education is provided as part of the in-service education programme.</p> <p>Trial fire evacuations are conducted as required. The facility is divided in fire cells. The approved fire evacuation plan was sighted.</p> <p>Security is maintained. The entire facility is secure with a security key pad at the entry. The</p>

		<p>security key pad pin number is displayed internally so that residents and family could come and go as they wished. Additional security arrangements are provided in the dementia area. Cameras have been installed in the hallways and communal areas. This has enabled better monitoring of incidents and accidents.</p> <p>A nurse call system has been installed. This includes an alert system to ensure call bells are attended to in a timely manner. Call bells were accessible/within reach, and are available in resident areas, including emergency bells for those in the dementia unit.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility was maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that was maintained at a safe and comfortable temperature. The entire environment is smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Responsibilities for infection control are clearly defined. The clinical leader (CL) is the delegated infection control coordinator and is responsible for collecting infection control data. The service has an infection control consultant and has utilised the support of the district health board infection control experts.</p> <p>The infection control programme is reviewed annually. The infection control committee has clinical and non-clinical members. Infection control is included in the monthly staff meetings and quality control committee meetings.</p> <p>The infectious diseases prevention policy is in place to prevent visitors suffering from, or exposed to and susceptible to, from exposing others while still infectious. Resident's families and relatives were encouraged not to visit when they were unwell. Hand sanitizers are in the main reception area as well as in the corridors.</p> <p>Interviewed staff members confirmed that infections were included in the hand-overs. The infection control policies and procedures are readily available for the staff members.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and</p>	FA	<p>The CL is responsible for facilitating infection prevention and control activities in the facility. The CL has attended relevant education on infection prevention and control. The infection control committee is composed of staff from the different departments in the facility. The RNs had liaised with the GP if there were concerns regarding known or suspected infections. The</p>

information resources to implement the infection control programme and meet the needs of the organisation.		district health board nurse specialists had provided expert advice regarding infection control. Interviewed staff members were knowledgeable regarding outbreak management and the spread of infections.
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	There are documented policies and procedures for the prevention and control of infection. Policies are aligned with current accepted good practice and relevant legislative requirements. Policies are readily available and procedures are practical, safe, and appropriate/suitable for the type of service provided. The service has consistently implemented the policies and procedures and best practice. All interviewed staff have demonstrated good knowledge on infection control prevention including the importance of proper hand washing. The interviewed residents were able to explain the importance of hand-washing.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control and prevention education is provided to staff members as a component of the orientation and ongoing education programme. The infection control in-service education is conducted regularly. Residents and families are provided with advice on infection prevention and control activities. Infection control awareness is included in the resident's meeting.
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	Surveillance for infection rates was carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. This was appropriate to the size and setting of the service. Infection rates were monitored and collated by the CL for analysis/trending. Infection rates were discussed during the monthly staff meetings and quality control committee meetings. The specific recommendations and interventions to reduce, manage and prevent the spread of infections were discussed during the monthly meetings as well as during the daily hand-overs. The use of antibiotics was monitored and recorded. Infections rates were collated for benchmarking and results were communicated to the staff and board of trustees.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	The use of restraints is actively minimised. There was currently one resident using a restraint (bedrail). An updated restraint register was sighted. The assessment and consent forms were evidenced in the restraint folder. Risk minimisation was documented in the long term care plan

restraint is actively minimised.		<p>of the resident on restraint. The restraint was evaluated regularly. The resident was also provided enough information regarding the risks of the restraint being used.</p> <p>There were no enablers in use during the day of audit.</p> <p>All staff received training on the use of restraints and enablers. Staff demonstrated good knowledge regarding restraint and enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical leader is the designated restraint coordinator. Responsibilities of the restraint coordinator are outlined in related policies. Restraints to be used for the resident are approved by the restraint approval committee prior commencing the restraint. The restraint use is also discussed in the quality control committee meetings.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator completes a restraint assessment form prior to commencing the restraint for the resident. This was evident in the file of the resident on restraint. The risk factors are identified in the assessment and the purpose of the chosen restraint is documented. The desired outcome is clearly documented in the long term care plan and the interviewed staff have demonstrated good knowledge in maintaining culturally safe practice.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has actively promoted the safe use of restraint. A current and updated restraint register was sighted. The long term care plan has the documented risk management plans required to ensure the resident's safety while using restraint. All interviewed staff have demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. The restraint minimisation policies and procedures are in place and accessible for all staff to read. There were no restraint-related injuries reported.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is evaluated regularly. The GP and the resident's family have signed the consent and evaluation forms. The evaluation form includes the effectiveness of the restraint and the risk management plans documented in the long term care plans. Staff members confirmed that</p>

		their feedback was obtained by the restraint coordinator when evaluating the restraint in use.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Monitoring and quality review of the use of restraint is conducted. Restraint is incorporated in the quality control committee meetings. Identified issues are discussed in these meetings as well as additional training that is required to support staff members. The restraint minimisation and safe practice policies and procedures are reviewed every two years. The minutes of the quality control committee are reported during the board of trustees meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	All staff who administer medications have completed annual medication competencies. During the observed lunch time medication rounds, the staff members were noted crushing medications in the rest home unit. The staff in the dementia unit has confirmed that medications were crushed for residents with compliance issues. Crushing medication is not included in the annual competency programme.	Training and competencies regarding crushed medication are yet to be implemented.	Complete staff competencies regarding the use of crushed medications. 180 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>A full analysis of the internal audit process resulted in an improved, and more targeted programme. This has resulted in the implementation of eight quality improvement projects in the last 12 months. Quality projects were planned, implemented and reviewed using a continuous improvement quality framework. Quantitative and qualitative data confirmed that these projects have resulted in improved outcomes for residents. For example a quality project regarding equipment, the environment and mobility has reduced skin tears from thirteen in 2014 to three (to date) in 2015. An improvement project regarding the use of behaviour management strategies has reduced incidents on aggression in the dementia unit from twelve in 2014 to none (to date) for 2015. Each quality initiative had been approved and monitored by the quality and risk monitoring group and included feedback from staff, residents and family members.</p>	<p>Implementation of internal audits has resulted in quality initiatives which improved the outcomes for residents.</p>

End of the report.