

The Napier District Masonic Trust - Elmwood House and 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 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:	The Napier District Masonic Trust
Premises audited:	Elmwood House and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 23 September 2015 End date: 24 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:	37

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elmwood House and Hospital provides rest home dementia level care and hospital level care for up to 39 residents. The service is managed by a facility manager and two clinical managers who job share. The resident and families interviewed spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with a resident, families, management, staff and a general practitioner.

There is one area identified that requires improvement relating to resident documentation.

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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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. This information is brought to the attention of residents (if able), and their families on admission to the facility. The resident and family members confirm their rights are being met, staff are respectful of their needs and communication is appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. The residents and family members are provided with information prior to giving informed consent and time is provided if any discussions and explanation are required.

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents' rights.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, and these policies are well understood by staff.

One of the clinical managers is responsible for the management of complaints 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.		Standards applicable to this service fully attained.
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The Napier District Masonic Trust is the governing body and is responsible for the services provided at Elmwood House and Hospital.

A business plan and quality and risk management systems are fully implemented. Documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly reporting by the facility manager and clinical managers to the governing body.

The facility manager is non-clinical and new to their position. The two clinical managers are both registered nurses and are responsible for the clinical service. The facility manager is supported by the clinical managers, a clinical leader and the quality and operations manager. Registered nurse cover is provided seven days a week.

There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidence corrective action plans are consistently developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff meetings are held and there is reporting on numbers of various clinical indicators, quality and risk issues and discussion of any trends identified. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management, which are implemented. One of the clinical managers is responsible for the management of the in-service education programme. In-service education is provided for staff via education study days and staff are supported to complete the 'New Zealand Qualifications Authority Unit Standards' to obtain the certificate in residential care, including the dementia modules. Staff records evidence human resource processes are being followed, orientations are being completed and individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The clinical managers and the clinical leader are on call after hours.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries into residents' clinical records is legible.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks post admission to the facility. Care plans are individualised and risk assessments completed. Residents' response to treatment is evaluated and documented. Care plans are evaluated six monthly.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The general practitioner completes three monthly reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications. There is one resident who self administers medicines.

The cook completed food safety training. The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian bi-annually.

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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All building and plant comply with legislation with a current building warrant of fitness displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

All residents' bedrooms provide single accommodation. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The internal and external areas are appropriate to the needs of the residents.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are in place to evaluate the effectiveness of these services.

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 restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. Policies and procedures comply with the standard for restraint minimisation and safe practice. Restraint assessment, documentation,

monitoring, maintaining care, and reviews are recorded and implemented. Residents using restraints had no restraint-related injuries.

Infection prevention and control

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

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are sanitary gels and hand washing facilities for staff, visitors and residents. Staff members are able to explain how to break the chain of infection.

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	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	New staff receive education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) as part of their orientation programme. On-going education on the Code is also provided to all staff. Staff demonstrate a good understanding of the requirements of the Code, outlining how these are then incorporated into their everyday practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The informed consent policy guides service providers in relation to informed consent. Resident files evidence formal, documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for the recent 'flu' vaccinations. The resident and families confirm they are supported to make informed choices, and their consent is obtained and respected.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate	FA	Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrate their understanding of the advocacy service, with contact details for the service

<p>the right of consumers to advocacy/support persons of their choice.</p>		<p>readily available.</p> <p>Residents and families are provided with information on the advocacy service as part of the admission process. The resident and family members confirm their awareness of the service and how to access this, although all stated they would feel comfortable about approaching staff if needed.</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 maintain their community interests and networks as much as possible and to visit with their families. The service's activities programme includes daily outings in the facility's mobility van and participation in community events. Community groups, different church denominations and entertainers also visit the facility on a regular basis.</p> <p>The service welcomes visitors, and has unrestricted visiting hours. Family members advised they feel very welcome when they visit. The resident reported they are supported by staff to access health care services outside of the facility.</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>One of the clinical managers is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that includes three complaints for 2015 and these were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place that ensures residents and their family are advised on entry to the facility of the complaint processes and the Code. The resident and families demonstrated an understanding and awareness of these processes.</p> <p>The complaints process is readily accessible and/or displayed. Review of quality and staff meeting minutes provide evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the quality and staff meetings.</p> <p>There have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB, Coroner, Police or the Accident Compensation Corporation (ACC) since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	<p>FA</p>	<p>During the admission process, new residents and their family are given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The clinical manager advised this information is discussed with them during the admission process and any</p>

<p>Consumers are informed of their rights.</p>		<p>questions they may have are answered. Staff are also available to discuss the Code and/or the advocacy service with the individual resident and their family at any other time if they require additional information or clarification. Posters of the Code in both English and Te Reo are also displayed at the facility.</p> <p>Family members are familiar with the Code and the advocacy service. Although none of those interviewed had concerns about any aspect of the services being provided, all stated they would feel comfortable raising issues with staff.</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>Residents are addressed by their preferred names. Each resident has a private room, which they are encouraged and supported to personalise. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. The resident and family members confirm they are treated respectfully and that the individual needs and preferences of residents are acknowledged and accommodated. The family satisfaction survey for 2015 indicates high family satisfaction concerning their relatives and their rights being respected.</p> <p>The residents' records include documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plans. The plans also include information on the residents' abilities, and strategies to maintain/maximise their independence. These plans have been developed in conjunction with residents where able and their family.</p> <p>The service's policy relating to abuse and neglect is understood by staff. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff have received education related to abuse and neglect. Staff employment contracts contain information relating to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met.</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>The service has a Maori health plan that guides staff. There are currently three residents who identify as Maori and eight staff of who most speak some Te Reo. The clinical manager also detailed the networks that have been established locally if additional support is required to support any residents who identify as Maori.</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>The individual preferences, values and beliefs of residents are included in the care plans reviewed. These plans include detailed interventions to ensure residents' individual requirements are accommodated. Family members advised they had been consulted about their relative'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 are 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>Family members stated that their relatives are free from any type of discrimination or exploitation. The clinical 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. The staff orientation programme includes information relating to discrimination and there is regular training for all staff on the topic. 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 receive services of an appropriate standard, including specialist services at the local district health board (DHB). Clinical policies, which are current and reflect best practice and are available to guide staff in care delivery. Staff are also supported to attend external education sessions.</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>A review of accident/incident forms showed timely and open communication with family members. Communication with family members is recorded in the communication sheets and progress notes (refer 1.3.3.3). Family members expressed satisfaction with how well they are kept informed about any change to the resident's condition and their involvement in resident care planning.</p> <p>Quarterly newsletters keep families informed of what is happening at Elmwood House and Hospital.</p> <p>The clinical manager advised that interpreter services are able to be accessed from the interpreter services if required. This information is also provided to families as part of the information/admission pack.</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 Napier District Masonic Trust is the governing body and is responsible for the services provided at Elmwood House and Hospital. A strategic management plan 2015-2016, a quality and risk management plan 2014-2016 and an organisational flow chart were reviewed. Documentation includes goals, mission statement, values, vision and objectives.</p> <p>The facility is managed by a facility manager (FM) who is non-clinical and who was appointed to this new position in August 2015. The facility manager has a background in management and is new to the aged care sector. The two clinical managers/registered nurses job share and are responsible for oversight of the clinical care provided. Prior to the appointment of a facility manager, the two clinical managers were responsible for managing the facility as well as the clinical overview. The two clinical managers have been co-managing since 2011, and interviews and observation evidence they are clear on what their responsibilities are and advised they work well together.</p> <p>The facility manager is supported by the clinical managers, a clinical leader who is a registered nurse and the quality and operations manager who is also the facility manager for the other local facility owned by The Napier District Masonic Trust.</p> <p>The annual practising certificates for the clinical managers, clinical leader and RNs were reviewed and are current. There was evidence in the facility manager's, clinical managers', clinical leader's and RNs files of ongoing education.</p> <p>The facility manager and clinical managers provide monthly reports to the trust and a selection of these were reviewed.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Elmwood House and Hospital is certified to provide 25 rest home dementia level beds and 14 hospital level beds. Twenty four dementia level beds and 13 hospital level beds were occupied on the first day of this audit. Dispensation from the DHB for the 25 dementia level beds has been granted.</p> <p>The service provider has funding contracts with the District Health Board (DHB) to provide rest home dementia level care and hospital level care and has contracts to provide 'Aged Related Residential Care' and 'Long Term Support Chronic Care'.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. The facility manager reported the clinical managers fill in for the facility manager if they are absent. The clinical managers fill in for each</p>

<p>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>other and should both be away at the same time, the clinical leader fills in for them. The facility manager and clinical managers confirmed their responsibilities and authority for their roles.</p> <p>Services provided meet the specific needs of the resident groups within the facility.</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>A quality and risk management plan is used to guide the quality programme and include goals and objectives.</p> <p>The family satisfaction survey was completed in June/July 2015 and results indicate that families are satisfied or very satisfied with the services provided.</p> <p>There is an internal audit programme and completed audits for 2014 and 2015, clinical indicators and quality improvement data is recorded on various registers and forms. Quality improvement data is being collected, collated, evaluated and analysed to identify trends and corrective actions are developed and evaluated, including issues identified at staff meetings.</p> <p>The clinical managers are responsible for a monthly risk management report which is presented to the quality and operations manager and to the trust. Combined quality; staff; health and safety; infection control and restraint meetings are held monthly and minutes were reviewed. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report that copies of meeting minutes and graphs of medication errors, falls and restraint use are available for them to review in the staff room. Observation confirmed this during this audit.</p> <p>A three monthly newsletter is provided to families, so that they are kept informed with what is happening at Elmwood House and Hospital. Families reported they find the newsletters informative and entertaining.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies and procedures have systems in place for reviewing and updating. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.</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>Staff are documenting adverse, unplanned or untoward events on an accident/incident form, apart from one instance (refer 1.3.3.3). Accident and incident forms are reviewed by the clinical managers and signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The clinical leader and registered nurses undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control.</p> <p>The clinical manager stated they have reported two essential notifications to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>One of the clinical managers is responsible for the in-service education programme provided. The clinical manager advised that in-service education is provided via three core education training days that are repeated once to make sure all staff receive training. Other education is also provided on a monthly basis. The clinical manager advised that all staff working in the dementia unit are required to complete the ACE dementia specific module first, then ACE core and advanced. The clinical manager advised all staff have either completed the dementia specific module or are currently completing it. Review of staff files confirmed this. There are two ACE assessors for the facility. Education records are maintained and were reviewed for 2014 and 2015.</p> <p>On-going competency assessments are current for medication management and restraint. The clinical managers and other RNs have the required interRAI assessments training and competencies.</p> <p>The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files. Employment agreements, police vetting, references, completed orientations and initial competency assessments were reviewed.</p> <p>There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, podiatrist and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals were sighted on staff files.</p>

		<p>The facility manager reported they are currently completing their orientation. Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. Registered nurses, care givers, the activities staff and the van driver have current first aid certificates.</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>	FA	<p>The staffing rationale policy is based on 'SNZ:HB 8163:2005 Indicators for Safe Aged-care and Dementia-Care for Consumers'.</p> <p>The rosters evidence the minimum cover is provided on the night shift and consists of one RN and two caregivers. A RN is in the hospital and two care givers in the dementia unit. Registered nurse cover is provided 24 hours a day, seven days a week.</p> <p>Care staff interviewed reported that there are enough staff on duty and they were able to get through the work allocated to them. Families interviewed reported there are enough staff on duty to provide their relative with adequate care.</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. These files are maintained securely. Electronic documentation is password protected and can only be accessed by designated staff. Archived files are also kept securely and easily retrievable.</p> <p>All components of the residents' records include the resident's unique identifier. The clinical records are well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals.</p> <p>Resident progress notes are completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes clearly identify the name of the person making the entry.</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>Residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. Admission agreements were signed for all residents files reviewed, and are kept securely in the residents' files. The facility requires all residents to have Needs Assessment Service Coordinators (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs. The registered nurses (RNs) admit new residents into the facility, confirmed during interview. Evidence of the completed admission records was sighted. The</p>

		RNs receive hand-over from the transferring agency, for example the hospital and utilise this information in creating the appropriate long term care plan for the resident.
<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>Staff identify, document and minimise risks associated with each resident's transition, exit, discharge and / or transfer. This includes expressed concerns of the resident and the family as confirmed during the on-site audit. The service uses a specific transfer form to document areas of potential risk which includes personal details of the resident, the person centred care plans and administration record.</p> <p>There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The service includes copies of the resident's records; GP visits; medication charts; the long term care plan; upcoming hospital appointments and other medical alerts when a resident is transferred to another health provider.</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>	FA	<p>Medicine management policies and procedures are in place and implemented, include processes for safe and storage, reconciliation, appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Medicine charts list all medications the resident was taking, including name, dose, frequency and route to be given. All entries are dated and allergies recorded. All charts have photo identification. Discontinued medicines are signed and the GP completes three monthly reviews.</p> <p>Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the hospital. The staff member checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines.</p> <p>Staff completed medicines management competencies. This required completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies.</p> <p>Self-administration of medicine policies and procedures are in place. There was one resident who self-administered inhalers. Medicines management training occurs for staff.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile is developed and reviewed regularly. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change. The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed.</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>There is an adequate documented process for the management of declines of entry into the facility. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services.</p> <p>The clinical managers (CM's) and the clinical leader (CL) assess the suitability of residents. When residents are not suitable for placement at the service, the family and or the resident are referred to other facilities, depending on their level of need.</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>The resident's needs, support requirements, and preferences are collected and recorded, however not within the required timeframes (refer to 1.3.3.3).. The RN completes a variety of risk assessment tools on admission. Additional assessments were sighted in the residents' files including: the medical assessment completed by the GP and recreational assessment completed by the activities coordinator. InteRAI assessments are completed by the registered nurses (RNs) for residents.</p> <p>Baseline recordings are recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families are involved in the assessment, care planning and review processes. The outcomes of the assessments are used in creating an initial care plan, the long term care plan and a recreational plan for each resident.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long term care plans reviewed were resident focused, integrated, and promoted continuity of service delivery. The facility uses an integrated document system where the GP, allied services, the RN, activities coordinator and visiting health providers document their care notes in residents' files.</p> <p>Goals are realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals.</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 receive adequate and appropriate services meeting their assessed needs and desired outcomes (refer to criterion 1.3.3.3). Interventions are documented for each goal in the long term care plans. Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Multidisciplinary meetings are conducted to discuss and review long term care plans. All resident files reviewed were signed by either the resident or by their family member.</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 activities programmes confirm that independence is encouraged and choices are offered to residents. The activities coordinator (AC) coordinates the activities programmes. The AC provides different activities addressing the abilities and needs of residents in the hospital and dementia care. Activities include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, music and one-on-one activities. Resident and family confirm they are satisfied with the activities programme.</p> <p>On admission, the AC completes a recreation assessment for each resident. The AC completes activity plans for each resident. Reviews of activity plans are completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changes. All resident files reviewed during the onsite audit had current activity assessments in place.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from: the GP; RNs; health care assistants; AC and other members of the allied health team. Daily progress notes are completed by the health care assistants and RNs. Progress</p>

manner.		notes reflect daily response to interventions and treatments. Residents are assisted in working towards their goals.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The RN stated that residents are supported in access or referral to other health and disability providers. The RN refers residents for further management to the GP; dietitian; physiotherapist; speech language therapist and mental health services. The GP confirmed involvement in the referral processes. The service follows a formal referral process to ensure continuity of service delivery. The review of residents' folders includes evidence of recent external referrals to the physiotherapist and specialists.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety has been 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. Observations provided evidence that hazardous substances are correctly labelled, the containers appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff. For example, gloves, aprons and visors were sighted.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on the 1 January 2016. Documentation evidenced appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme that ensures buildings, plant and equipment are maintained to an adequate standard. Documentation reviewed, interview of the maintenance person and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current. Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment. There are several external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken

		<p>in the areas. Residents are protected from risks associated with being outside.</p> <p>Families confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Families confirmed their relative is able to move freely around the facility and that the accommodation meets their needs. Observation during the audit confirmed this. The dementia unit is a purpose built unit which allows for freedom of movement. The external environment is safe and secure and easily accessed by residents.</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 two bedrooms in the hospital unit that have full ensuites. There are adequate number of accessible communal showers, toilets and hand basins for residents. 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 and are maintained at a safe temperature.</p> <p>Communal toilets and showers have a system that indicates if 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 in the dementia unit are large enough to provide personal space for residents. The bedrooms in the hospital unit are large and allow staff and equipment to move around safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Families confirmed there are alternate areas available to their relative if communal activities are being run in one of these areas and they do not want to participate in them.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and</p>	FA	<p>Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons.</p> <p>All laundry is currently washed on site. There is a dirty to clean flow provided in the laundry. A</p>

<p>hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>laundry person is responsible for the management of laundry and described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents. The operations manager advised that laundry processes have been reviewed and it is planned that all laundry apart from personal laundry will be transported off site for washing.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described the cleaning processes.</p> <p>Observations evidenced safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals are labelled and stored safely within these areas; chemical safety data sheets or equivalent are available. A sluice is available for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Families stated they are satisfied with the cleaning service. The family satisfaction survey, meeting minutes and corrective actions following audits evidence there is an on-going issue with aspects of the management of laundry. The quality and operations manager reported that it is planned that laundry from Elmwood House and Hospital will be washed at the other nearby facility also owned by The Napier District Masonic Trust.</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>	<p>FA</p>	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy and procedures for visitor identification are available. Policy and procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.</p> <p>A New Zealand Fire Service letter approving the fire evacuation scheme dated 9 November 2005 was sighted. The last trial evacuation was held on 27 July 2015.</p> <p>Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets and cell phones.</p>

		There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and are available in resident areas. The resident and families confirmed they or their relatives have a call bell system in place which is accessible and staff respond to it in a timely manner.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Procedures are in place to ensure the service is responsive to resident and family feedback in relation to heating and ventilation, wherever practicable. Families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Areas outside the building are available for any resident or staff who smoke.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The infection control coordinator (IC) is the RN. The infection control programme is reviewed annually. Infection control is part of the monthly staff meeting agenda as well as part of the monthly IC meetings.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing.
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	FA	Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of services provided.

the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<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>The organisation provides relevant education on infection control to all service providers, support staff, and residents. The infection control education is provided by an external trainer. The RN reported that hand-washing and infection control training is completed. The training programme includes hand washing and standard precautions. Residents interviewed are aware of the importance of hand washing.</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>The RN is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections, for example facility-acquired infections, are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented in the infection log maintained by the infection control coordinator.</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that are specified in the infection control programme. Infection control processes are in place and documented. The infection control surveillance register includes monthly infection logs and antibiotics use. The organisation has an internal benchmarking system and identifying trends forms part of the quality processes. Infections are investigated and appropriate plans of action were sighted. The surveillance results are discussed in the staff meeting.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There were seven residents using restraints and no residents using enablers at the facility on audit days. The service has a documented system in place for restraint and enabler use, including a restraint register.</p> <p>Restraints used in the facility include restraint briefs and bedrails. The files reviewed for restraint use showed enablers (when used) were voluntary and the least restrictive option for the residents. Residents who use restraints have risk management plans in place. The restraints are documented in the long term care plans. There were no restraint related injuries reported. Bedrails have specialised bedrail covers when in use, as part of the risk management plan. One of the RN's is the restraint coordinator.</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>	<p>FA</p>	<p>The restraint coordinator completes a restraint assessment which is then discussed with the GP prior to commencement of any restraints. The restraint approval group is defined in the restraint minimisation and safety policy and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. Caregivers are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour is evident. Staff members are made aware of the residents using restraints during monthly staff meetings. This was confirmed during staff interviews.</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>	<p>FA</p>	<p>Restraint assessments include: opportunity for the identification of restraint related risks; however this was not accurately recorded. The service recorded underlying causes for behaviour that required restraint; past history of restraint use; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury for example the use of low beds, mattresses and sensor mats. Restraint consents are signed by the GP, family and the restraint coordinator. The restraint monitoring forms are completed by the caregivers. Restraints are incorporated in the long term care plans and reviewed three monthly. The restraint register is up to date.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint coordinator evaluates all episodes of restraint. Long term care plans are evaluated six monthly. Reviews includes the effectiveness of the restraint in use, restraint-related injuries and whether the restraint was still required. The family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed three monthly..</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and</p>	<p>FA</p>	<p>The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and includes restraint minimisation reviews. The content of the internal audits include the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice is also included in the quality reviews.</p>

quality review of their use of restraint.		
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Three tracers were completed, two in the hospital and one in the dementia unit. The tracers related to wound care management at the facility.</p> <p>One of the tracers in the hospital i) did not have a wound care plan in place until four days after the injury, ii) an incident / accident record was not completed at the time of the injury, iii) family and the GP were not informed at the time of the injury, and iv) progress notes and handover sheets did not reflect continuity of care.</p> <p>During the on-site audit the service mitigated risk by completing an incident /accident record for the management of risk, they already implemented a short term care plan for the management of the injury, the family and GP were informed during the on-site visit and the service started including the progress of the wound in progress notes and handover.</p>	Timeframes relating to the management of a wound and related documents have not been met for one resident with pressure injury.	<p>i) wound care plans for all wounds at the time of the incident, ii) incident / accident records to be completed at the time of the incident, iii) Family and when needed, the GP to be informed of incidents / accidents and progress notes and handover records to facilitate continuity of care.</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.