

# The Marianne Caughey Smith-Preston Memorial Rest Homes 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 The DAA Group 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:

<b>Legal entity:</b>	Marianne Caughey Smith-Preston Memorial Rest Homes Trust Board
<b>Premises audited:</b>	Caughey-Preston Hospital  Marianne Court  Ventnor Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 5 September 2016      End date: 7 September 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	148

# 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

The Marianne Caughey Smith Preston Memorial Rest Homes Trust Board (CPT) provides rest home, hospital and secure dementia care.

Changes to the organisation since the previous surveillance audit in September 2014 are a reduction in the number of clients who could be accommodated on site from 245 beds to a total capacity of 181 beds. This was due to the planned closure of an older building and the conversion of four-bed hospital rooms into large single premium rooms. This change also resulted in a reduction of staff numbers from 293 to 203. There have been no changes to the scope of services.

This re-certification audit was conducted against the Health and Disability Services Standards and the provider's contract with Auckland District Health Board (ADHB).

The audit process included the review of policies and procedures, the review of clients and staff files, observations, interviews with clients and their family, management and staff. The contracted general practitioners could not be interviewed on site and were not contactable by telephone. A nurse practitioner was interviewed on site.

This audit did not identify any areas requiring improvement. There are six areas rated as continuous improvement resulting in safer and improved services for clients and staff. These are acknowledged in quality and risk management systems, staff management-specifically training and orientation, and clinical aspects of service delivery including assessment processes and infection prevention and control.

## 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.
--	--	--

The facility provides services that reflect current accepted good practice. Consumer rights is explored by new employees as part of their orientation package and there is regular in-service education for all staff on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers 'Rights (the Code) which also includes a cultural safety component. Staff demonstrated good knowledge and practice of respecting clients' rights in their day to day interactions. Families and clients interviewed expressed satisfaction with the caring manner and respect that staff show towards each client.

There were no clients who identified as Maori residing at the service at the time of audit. There are no known barriers to clients accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the clients as individuals and as a collective. Written consents are obtained from the clients' families, enduring power of attorney (EPOA) or appointed guardians, when necessary. Clients are encouraged and supported to maintain strong community and family links.

The complaints management system meets the requirements of the Code and is known by staff, clients and their families. Families reported that staff immediately respond to and begin to address any concerns they raise. There has been one external investigation by the district health board since the previous audit. This was also reported to the Office of the Health and Disability Commissioner who did not investigate directly. The matter has been fully resolved and is now closed.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

There have been a few changes of membership within the Caughey Preston Trust Board. The board continue to meet monthly and are kept fully informed about all aspects of the organisation. The general manager (GM) and all members of the senior management team are appropriately qualified for their positions and have extensive experience working in the aged care sector.

The quality and risk management systems meet these standards and continue to be improved upon. The organisation clearly demonstrates an ethos and commitment to continual quality improvement. Information which monitors the quality and extent of the services being provided is consistently reviewed, evaluated and compared with previous data generated by the organisation. CPT continues to benchmark some of its quality data against similar services locally and nationally.

All adverse events reviewed were reliably reported and investigated. The organisation has made essential notification where required to the district health board and the Ministry of Health.

Staff are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff and has been strengthened and endorsed by an external training provider. Ongoing staff education is planned and coordinated to ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Training occurs at least monthly through in-service education sessions, and through self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals are occurring regularly. Staff management and workforce development were assessed as being an area of strength within this organisation.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of clients who are assessed as requiring either hospital, rest home or secure level dementia care. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week meets contractual requirements.

Consumer information management systems meet the required standards. Archived records were being stored securely and all resident information is integrated and readily identifiable using relevant and up to date information.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

Pre-admission information clearly and accurately identifies the services offered. A package which includes pamphlets and booklets provides information and identifies services offered within the facility. The service has policies and processes related to entry into the service.

Clients are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the client. This is developed with the client, family and existing community supports and health care professionals. When there are changes to the client's needs a short term plan is developed and integrated into a long term plan, as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All clients have interRAI assessments completed and individualised care plans related to this programme.

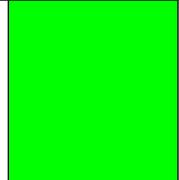
Clients are reviewed by the GP or nurse practitioner (NP) on admission and assessed thereafter either monthly or three monthly depending on their needs or more frequently if their condition changes. Referrals to allied staff, the DHB and other community health providers are requested in a timely manner and planned and co-ordinated based on the individual needs of the client. A team approach to care is provided ensuring continuity of services.

Activity coordinators provide planned activities meeting the needs of the clients as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives. Clients are encouraged to maintain links with family and the community.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary requirements accommodated. The service has a four week, winter/summer rotating menu which is approved by a registered dietitian. There is an alternative option to the main meal if required. Client's nutritional requirements are met. Clients and family have access to hot and cold beverages machines/kitchenettes situated throughout the two of the three units.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff are responsible for medicine management and assessed as competent to do so.

## 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.
--	---	--

There are effective and safe processes for managing waste and hazardous materials. The buildings have a current warrant of fitness. The majority of client bedrooms are for use by a single occupant. All are spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture to accommodate the needs of the clients. External areas are safe and well maintained.

Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Regular monitoring and reporting on the outputs from cleaning and laundry services contributes to high performance and good standards in these areas.

The organisation is focused on providing regular in-depth training and information to all staff about effective management and responses to emergencies. Emergency systems and the equipment needed for emergencies, including the ability to provide

sufficient food and water for the number of clients for at least three days, is being checked frequently. There is an approved evacuation scheme and systems for ensuring that all staff attend fire updates at least annually. All clinical and designated non clinical staff are expected to hold a current first aid certificate and this is routinely monitored by senior staff.

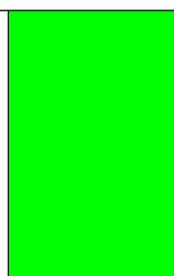
All parts of the facility are heated in ways that provide comfortable and constant internal temperatures. Electrical equipment is checked annually. All medical equipment is serviced and calibrated annually. Hot water temperatures are monitored.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	---	--

The organisation uses best known processes for determining safe and appropriate restraint and enabler use. On the days of audit the restraint register was up to date and contained clear detail about all the clients who required interventions for safety. The methods used for assessment, consent and approval, monitoring, evaluation and review meet all the requirements of the Restraint Minimisation and Safe Practice Standard.

## Infection prevention and control

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

The service has an appropriate infection prevention and control management system that reflects current and up to date practice. The infection control programme is implemented and provides a reduced risk of infections to staff, clients, families and visitors.

Education is provided for staff, and when appropriate, the clients and their families.

There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. There has been an infection outbreak since the previous audit. The outbreak was managed and met all legislative and standard requirements. The infection surveillance results are reported and discussed at appropriate and relevant staff and clients' meetings and any required actions implemented as documented in policy and processes. An external contractor benchmarks and reports data quarterly with 75 other facilities.

## 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)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	6	95	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) including a cultural safety component. Services are provided in a manner that is respectful of consumer rights, facilitates consumer choice, minimises harm, and acknowledges cultural and individual values and beliefs. Prospective clients and families are provided with a copy of the Code on admission and a copy is displayed throughout the facility in full view for clients, staff and visitors, available in audio if required and evidenced as discussed again in client/family meetings.</p> <p>On commencement of employment all staff receive initial induction orientation training regarding clients’ rights with regular ongoing training implemented at clinical training days. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the clients’ rights in a manner that was individual to the client’s needs.</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>	<p>FA</p>	<p>An informed consent policy is in place. Every client has the right to be given adequate information in a form that they can understand and to then be supported to receive, refuse and withdraw consent for services. A client, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation. An advance care pathway has been developed and clients and families are encouraged and supported to complete this as part of the admission plan.</p> <p>The clients' files reviewed had consent forms signed by the client, family and/or enduring power of attorney (EPOA) where appropriate. Family interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative's care and decision making.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The advocacy policy documents that all employees have a responsibility to uphold clients' rights at all times and to represent their best interest. All clients receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board.</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>There are no set visiting hours and family are encouraged to visit. Clients are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family interviews and documented in daily and planned activities in resident's progress notes and care planning, such as church services, links with the local kindergarten and other community events.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaint management system complies with right 10 of the Code and the requirements of this standard. At the time of this audit there had been two serious complaints received since the previous audit. One was initiated in mid-2015 by the Auckland District Health Board who conducted an extensive investigation and closed it off in February 2016. The same matter had also been raised with the Office of the Health and Disability Commissioner who conducted a desk top investigation and advised the service provider that the matter was closed in August 2016. Changes to staff communication processes and clinical practice have been implemented as a result. The other complaint was managed by the GM and Quality and Development (Q&amp;D) manager who carried out an extensive investigation, implemented remedial actions and maintained communications with the complainant, until the matter was resolved. These complaint matters were validated by review of documentation related to the matters and interviews with senior management. Other complaint matters are received and managed by the nurse manager or manager of the service area. These are reported at monthly Operations and Quality, Clinical Ethical committee meetings. Review of the complaint documentation and interview with the GM showed that the complaint procedures were adhered to, investigations occurred and actions happened in a timely manner which resulted in resolution of the complaint.</p> <p>Staff, clients and the family members interviewed demonstrated knowledge and understanding of the complaint process. Families described staff as being open, responsive and keen to address any matters they raised with them.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the client and family on admission and is evidenced in the admissions agreement.</p> <p>The family that were interviewed reported that the Code was explained to them prior to admission and on admission day. The Code of Rights and process was also regularly discussed at family/client meetings. Family expressed that they were happy with the care at the facility and provided by the staff. The 2016 client satisfaction survey showed that</p>

		clients/families were 72% (very satisfied) and 28% (satisfied) with the care provided by staff.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A dignity and privacy policy requires the visual privacy and personal space of clients to be respected and observed at all times and that staff will facilitate the use of private space for interaction with families and significant others. The clients' files reviewed reflected that clients received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families interviewed reported that the staff are meeting the needs of their relatives. Families interviewed reported that staff often go above and beyond the families' expectations when meeting the needs of their relatives.</p> <p>The family members interviewed reported that their relative was treated in a manner that showed regard for the client's dignity, privacy and independence. At the time of the audit staff were seen to knock on clients' doors and await a response before entering. The use of occupied signs on bathroom/toilet doors when in use were noted.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions. The 2016 client satisfaction survey showed that clients were 71% (very satisfied) with the privacy and dignity that staff provided.</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>	FA	<p>The Maori health plan supports any clients that affiliate with Maori to be supported in their cultural values and beliefs. The staff interviewed demonstrated good understanding of practices that identified the needs of the Maori client and importance of whanau to their Maori culture. Staff also demonstrated knowledge of the 'Tapa wha' model and were able to discuss the Service Coordinator's role/process of contacting local iwi and kaumatua in the community and cultural advisory support through the DHB as required. Staff interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori clients.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>The spiritual, religious and cultural beliefs of a client is supported by a policy that supports and acknowledges clients can be of the same</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>culture but can have very different beliefs and practices. The policy acknowledges the importance of the facility and their staff understanding the client's specific needs. Staff liaise with family prior to and on admission day and then at regular intervals to ensure cultural or religious visits/support continues as appropriate. Clients have access and are supported to attend services within the facility.</p> <p>Staff education on cultural sensitivity and spirituality is ongoing. Families interviewed were happy with the care provided by those staff who also identify with a different culture. The 2016 client satisfaction survey showed that clients/families were 65% (very satisfied) and 35% (satisfied) with the cultural needs and support provided by staff.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family reported that they are very happy with the care provided. The families expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries. Education is provided at the time of staff induction and staff regularly attend ongoing education.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed and evidenced in interviews with the registered nurses, health care assistants and care planning process. Policies and procedures are linked to evidence-based practice. The facility has close links with specialist services and clients are visited regularly by GPs, the NP, the mental health services, the podiatrist, hospice, dietician, geriatrician and different DHB nurse specialists and consultants.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The communication policy is based on the principle that clients and their families have a right to know what has happened to them and to be fully informed within 24 hours after an adverse event occurs. The families interviewed confirmed that they are kept informed of their relative's wellbeing. This includes any incidents adversely affecting their relative and they were happy with the timeframes that this occurred.. Evidence of timely open disclosure was seen in clients' communication sheets, integrated progress notes, accident/incident forms, from an observed phone call to a relative to a relative and at</p>

		<p>staff handover.</p> <p>All clients and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all clients spoke English.</p> <p>The 2016 client satisfaction survey showed that clients/families were 59% (very satisfied) with communication provided by staff.</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>	FA	<p>On the days of audit there were 37 residents requiring rest home level care, 95 residents requiring hospital level care and 19 in the secure dementia wing.</p> <p>The organisation has a clearly defined scope, direction and goals documented in the 2015-2016 Strategic and Annual Plan. Monthly progress against the plan and a mid-year review of the plan structure is documented and reported by the general manager (GM) to the board for sign off.</p> <p>There have been no significant changes within the board who continue to meet monthly. The general manager (GM) provides a comprehensive written report to the board containing narrative and statistical information on occupancy rates, and an operational review that reports on achievements in staff training and education, quality initiatives, interRAI, infection control, palliative care, health and safety matters, audit outcomes, statistical staffing information and outputs from other service areas, financial reports and complaints and compliments. The GM, who has been in the role for eleven years, has extensive experience as a manager in the health sector and is qualified in business management and leadership. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>Discussions with senior management and other staff confirmed that temporary cover during the GMs planned absences is delegated to the Quality and Development manager. Clinical management cover is provided for the Nurse Manager roles. Staff stated these arrangements were proven to be effective and ensured continuity for</p>

		staff, clients and their families.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Staff at Caughey Preston Trust (CPT) are maintaining an ethos of continuous quality improvement across all areas of organisational management and the ways in which they deliver services. There is a long term commitment to embedding best known clinical practice in client care, growing a skilled and loyal workforce and upholding their reputation in the sector. This was evidenced by a pre-audit document review of policy, plans and other service literature, which clearly described the organisation's approach to continuous quality improvement. On site evidence included considering the outcomes of ten strategic initiatives implemented and evaluated since the previous surveillance audit, the review of board reports and their meeting minutes, the meeting minutes from committees who meet monthly (see below for description of all committees) and interviews with all levels of staff. The Quality and Development Manager (Q&amp;D Manager) chairs the majority of these meetings and the GM is always provided with written and verbal updates and/or attends the meetings.</p> <p>The Quality Clinical &amp; Ethical Committee (QCE) comprised of nurse managers, the infection control nurse, and one other RN, review outcomes from quality activities such as internal audits, feedback from surveys, and progress on quality initiatives. This committee determines actions to address quality issues. The Client Risk Committee (CRC) comprising the Allied Health Service Manager (whose portfolio includes physiotherapy services, activities and external health providers), three Clinical Support Nurses (two of whom are restraint coordinators) review analyse and trend incident and accident data, the status of 'at risk' clients, restraint matters and the progress of their projects. The Senior Management Team (SMT) comprised of the GM and five service managers review organisational progress and trends revealed from monthly comparative key performance indicator (KPI) data. This analysed data is also reported to the Board by the GM. The Health and Safety Advisory Committee, comprised of the Facilities Support Services Manager, all health and safety representatives, catering and household staff and chaired by the Q&amp;D manager, consider the results consider the results of internal audits conducted on the facility, such as hot water, food, fire training and emergency disaster response projects, laundry and cleaning</p>

	<p>activities, delivery plans for fire safety and emergency. The Clinical Management Team (CMT) plan and determine workforce training and development. There are also monthly KPI meetings with the Quality and Development Manager, clinical managers and the Catering Supervisor to review and elaborate on trends in their respective areas. All matters that require investigation and remedial actions are recorded as corrective actions on the meeting minutes and stay on the agenda until evidence the matter has been resolved is cited.</p> <p>A synopsis of information from these meetings is filtered down from service managers to the RN and staff meetings and significant reports are displayed in staff areas. All of the staff interviewed described the ways they are either directly involved with quality and risk monitoring or informed about quality and risk activities. Incidents and accidents, infections, restraint matters, clients at risk and compliments and complaints are also reported and discussed at weekly operations meetings.</p> <p>It was clear that the areas selected as strategic/quality initiatives had been identified as a priority from data analysis, adverse events, unfavourable trends, new problems or new information. Examples of some of the strategic initiatives that have been implemented and/or completed in the past two years are; alignment of internal training, embedding interRAI into the clinical culture, keeping mobile dementia clients safe from falls, a significant moving and handling project, pressure area risk management-including wound management and skin care programme development, infection control improvement programmes and emergency response projects. Some of these are detailed as evidence for ratings of continuous improvement in standards 1.2.7, 1.3.4, 1.3.6 and infection control 3.5. Quality improvement focus groups of people (who are selected for their knowledge and ability to champion the matter at hand) are formed to address quality improvement issues.</p> <p>This standard is rated as continuous improvement for the ongoing modifications to the methods used for monitoring the quality of services delivered. This is expanded on in criterion 1.2.3.5.</p> <p>Other ways that the service monitors service delivery are via client and staff satisfaction surveys, feedback from external stakeholders such as families, allied health professionals, ADHB and the local needs</p>
--	---

		<p>assessment and service coordination agency (NASC). Each of the three service areas hosts six monthly family meetings to build relationships and encourage communication with families. Results of internal audits show improved outcomes in all areas of service delivery. The service involves clients and their families in all decisions about service delivery which impacts them individually and collectively.</p> <p>Policies are reviewed against current standards, legislation and known best practice two yearly, or earlier when required. The policies include reference to the requirements for interRAI assessments and care planning.</p> <p>Risk management occurs in a variety of ways. This is clearly documented in risk management plans and policy and is apparent in the GM's reports to the board. Staff interviews and documentation revealed that risk awareness occurs across all layers of the organisation and any potential or actual risks are immediately reported. CPT is a member of the Employer and Manufacturers Association (EMA), Standards NZ and the Care Association of NZ. Staff regularly attend external meetings and educational opportunities within the sector to detect potential risks within the industry, changes in legislation, guidelines and/or contractual changes.</p> <p>Review of the minutes of the health and safety meetings and interview with the committee members showed that all health and safety matters, including any actual and potential risks to staff and residents, are managed to prevent occurrence. A number of the committee members hold stage two qualifications in health and safety and all demonstrated understanding of the new legislation and its implications. There have been no injuries to staff who carry out cleaning, laundry or clinical duties that required reporting to Worksafe NZ. The organisation is maintaining its tertiary accreditation with the Accident Compensation Corporation (ACC) for its workplace safety management plans and this is scheduled to be reaccredited in early 2017.</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</p>	<p>FA</p>	<p>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at weekly</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>operational meetings and then trended and further evaluated at monthly KPI meetings, and by the client risk committee. Avoidable events are evaluated and actions are implemented to prevent recurrence. Observation on the days of audit confirmed that incidents are discussed at shift handover, and trending data is displayed. Each client's file contained incident reports which facilitates a ready review of risks.</p> <p>The GM is responsible for essential notification and reporting and understands the statutory and regulatory obligations. Due process is followed, as evidenced by sighting records of an immediate notification to the DHB and MoH of a pressure injury in 2016.</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>CI</p>	<p>Recruitment for new staff adheres to best known employment processes. Each of the 20 staff files reviewed on site contained evidence of formal interviews, verification of qualifications and copies of notes from referees who had been contacted and police checks completed before confirming an employment agreement. The personnel records also showed that the registered nurses and enrolled nurses have current practising certificates, and that each role has a job description. All staff are employed on individual or collective employment agreements which includes a trial 90-day period. Credentialing processes adhere to the policies in place and best practice frameworks. Other health practitioner practising certificates are sighted by the GM and clinical managers and a register is maintained. There were copies of current APCs in the staff files for RNs and other registered practitioners.</p> <p>The orientation programme supports new staff to integrate into their new work team and routines. The programme covers a variety of topics that are essential to the safety and security of the new staff member, clients and the organisation. The competency based package for RNs, enrolled nurses (ENs) and health care assistants (HCAs) specifically provides training in regard to fire and emergency procedures, infection control procedures, manual handling and transferring. All staff files contained evidence that orientation/ induction and an initial competency assessment and performance development review occurred after the first 90 days of employment. The innovations and external evaluation of this programme in 2016 is rated as</p>

		<p>continuous improvement.</p> <p>The organisation has succeeded in re-engaging staff with training and development opportunities. This was demonstrated by feedback from 27 staff and management personnel and review of an evaluation report. Statistical data confirming improvements was sighted in comparative staff surveys, the organisations database and the contents of performance appraisals in 20 staff files. The sighted internal training programme for 2016 contains a full page of topics (approximately 23 sessions) being presented each month for selected groups of staff by qualified senior staff or external experts. The number of training sessions completed and evaluated each month is reported to the board and attendance is monitored by senior management. This is an area of continuous improvement and is detailed in criterion 1.2.3.5.</p> <p>Staff files contained evidence of performance development reviews (PDR) occurring annually and the GM monitors that these are kept up to date by accessing the staff database. Education needs are identified during the PDR process. Senior managers are provided monthly print outs of their staff member's progress with their education goals and attendance at compulsory sessions, such as fire safety awareness, moving and handling, First Aid/CPR emergency preparedness and health and safety. The service supports health care assistants to complete industry recognised education related to aged care.. The selected sample of six staff rostered to work in the secure unit had all completed the required unit standards in dementia care. This was confirmed by sighting copies of the certificates and accessing an external education agencies database.</p> <p>Review of individual training records and the organisation's database confirmed that more than 95% of care staff, activities staff and drivers are maintaining certificates in first aid and that RNs and enrolled nurses (ENs) competency in medicines administration is being practically assessed by the clinical support nurses at least annually.</p> <p>Fire drills are occurring every six months, desk top emergency scenarios which involve staff from different disciplines (such as managers, administration staff, food service staff, household support services and care staff) are staged and evaluated annually. Other training subjects offered regularly include restraint, falls prevention,</p>
--	--	--

		<p>pain management, moving and handling, infection prevention and control (for example, 'The 5 moments of hand hygiene', surveillance summary, cleaning blood and body spills, influenza, respiratory infections, scabies, what to do in an outbreak) palliative care, Parkinson's, continence, pharmacy training, dietician, CPR/first aid and verification of death, chemical safety, kitchen safety and other health and safety topics, and a specialist customer service and communications training programme titled Tetramap.</p> <p>CPT is also reviewing the option of becoming an Eden Alternative Facility.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a clearly described staffing rationale. Rosters sighted and interview with different levels of staff confirmed there are more than the required numbers of skilled and experienced staff on all shifts in each service area, to meet the minimum requirements of the provider's agreement with the district health board (ARC contract). Staffing allocation takes into account the acuity and support needs of individual clients who require 1:1 supervision. Physiotherapy assistants and activities coordinators are employed to work differing shifts seven days a week to meet client need. For example, there are morning and afternoon activities coordinators shifts in the secure unit. There are contracts in place for medical officers, registered physiotherapists, podiatrist and dieticians to provide regular on site services. CPT have an agreement with their preferred staffing bureau to maintain and provide the same pool of RNs and HCAs who are familiar with the facility and its clients and who have been trained to understand CPT systems.</p> <p>Rosters and staff interviews confirmed that auxiliary staff (kitchen hands, cooks, cleaners, laundry, maintenance and orderly staff) are employed for sufficient hours to meet service demand. The laundry operates six days a week and cleaning staff are on site seven days a week. CPT has a low rate of staff turnover and is currently retaining its total staff for 7.39 years. Some staff have been employed for more than 40 years. The average length of time for RNs is 7.31 years and 6.88 years for HCAs. The content of staff files contained examples of robust performance management with fair and firm communications where performance was falling below the expected standards set by</p>

		the GM.
<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>The client's name and date of birth and national health index (NHI) are used as the unique identifier on all clients' information sighted. Clinical notes were current and integrated with medical and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. Prior to the day of admission all relevant information is entered into the client's file by the receptionist. On the day of admission the RN enters information following an initial assessment and medical examination by the GP or NP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP or NP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each client's record reviewed. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for ten years then securely destroyed by a contractor.</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 client's admission agreement is based on the Aged Care Association agreement which is individualised to the facility. The clients' records reviewed have signed admission agreements by the client/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. All potential enquires and prospective new clients are supported by the service co-ordinator to ensure that both the client and family have information required to make an informed decision. This support includes face to face meeting/s and discussions, written information and viewings of the facility.</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 service uses not only the DHB's processes and forms for admission and discharge to and from the acute care hospital, which includes a transfer template, envelope and check list requiring specific information to accompany the client, but their own transfer form which provides more specific care planning intervention. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the client's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are</p>

		also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by clients. At the time of audit, no resident was self-administering medications.</p> <p>Medications for clients are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in medicine trolleys individually in the different treatment rooms which are locked when not occupied. Locked safes are used for controlled medications and the medicine registers were sighted. Medications that require refrigeration are stored in separate fridges with recorded temperatures documented.</p> <p>The forty-two medicine charts sighted have been reviewed by the GP/NP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the client.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurses administering medicines at the time of audit demonstrated competency related to medicine management and attends regular and compulsory annual training provided by a pharmacist and competencies are updated annually.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></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>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the</p>

		<p>food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing and regular food safety training.</p> <p>There is a four week rotating winter/summer menu that has been reviewed by a dietitian. An assessment is completed for all new admissions and six monthly for current clients. Where unintentional weight loss is recorded, the resident is discussed with the NP and referred for a dietitian review, who visits the facility monthly or sooner if an urgent assessment is required.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs and special diets of the resident are catered for. Food is available for staff to provide clients with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner, also supporting individual clients. All main meals are supported by morning and afternoon tea which includes home baking.</p> <p>All meals are cooked in the onsite kitchen. The food is then delivered by truck to the different areas of the facility using mobile hot and cold temperature controlled food boxes. Clients have the option of trays in their rooms, however all clients are encouraged to have their lunch and evening meals in the dining rooms to encourage appetites and socialisation. Clients and families have access to kitchenettes throughout the facility that support access to hot and cold beverages.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The general manager interviewed reported that the service does not refuse a client if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the client, the client, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the client's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the client. The client agreement has a statement that indicates when a client is required to leave the service. The admission agreement has a clause</p>

		on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the client.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service has implemented the electronic interRAI assessment and assessments are carried out by two dedicated registered nurses. Specific assessment tools for all clients remain paper based and includes falls, skin integrity, challenging behaviour, nutritional needs, continence, communication, end of life and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The clients' files reviewed have assessment information obtained from any prior place of living, services involved, the client, and where applicable the client's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. Within forty-eight hours of admission a multidisciplinary team meeting is facilitated to ensure that the client has been referred to required/relevant and requested resources. All 21 of the client's files reviewed have falls risk and pressure injury risk assessments.</p> <p>The families interviewed reported their relative receives 'above and beyond the care required' to meet their needs.</p>
<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>The 21 residents' files reviewed have care plans that address the client's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the clients' files. Also evidenced is the assessment of techniques used that is individual and specific to the clients with interventions and evaluations sighted. The health care assistants interviewed demonstrated knowledge about the individual client's they care for.</p> <p>The clients' files reviewed included activity care plans identifying the client's individual activity, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the clinical support nurse, registered nurse, health care assistants and activity staff and medical and allied health services which include initially the GP/NP, podiatrist and physiotherapist. The registered nurse and health care assistants interviewed reported they</p>

		<p>receive adequate information to assist with the client's continuity of care. This was also evidenced at the time of actual day of admission, shift handover (verbal and paper) and staff communication book.</p> <p>The family interviewed reported they were very happy with the quality of care provided at the service.</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	<p>Clinical management policies and procedures promotes a holistic and extensive approach to an assessment on admission which includes weight, continence and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurses and health care assistants demonstrated good knowledge of individual clients, providing individual and specific care that is reflected in the client's care plan. The clients' files showed evidence of discussions and involvement of family and significant others. The family interviewed reported that the staff knew their relatives very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the clients. The care plans reviewed recorded interventions that are consistent with the client's assessed needs and desired goals. The registered nurse and health care assistants interviewed reported they have input into clients' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the clients' needs.</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>	FA	<p>The activities programme uses a framework to empower the clients to have the opportunity to be valued and respected. The clients are provided with opportunities that are of interest to them from the past and present and focuses on the five senses and reminiscing. Clients are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices of the clients.</p> <p>There are a total of six activity co-ordinators who are rostered to work Monday to Sunday, and are on site from 9.30 am until 5 pm supporting clients in the three different areas of the facility. The weekly activities</p>

		<p>plan sighted is developed based on the client's individual needs and interests and can be easily adapted and changed depending on the client's physical ability, interest and reaction at the time. Regular activities include daily newspaper reading and exercises and church services. All public holidays and special events are celebrated. For clients who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours. Staff promote social interaction by inviting and encouraging all clients to join in activities together in the main lounges.</p> <p>The clients' files reviewed have activities and social assessments that identify the client's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each client and assessed and reviewed based on the enjoyment and interest of the client. The goals are updated and evaluated in each client's file monthly.</p> <p>A challenging behaviour, assessment tool and monitoring form is developed for clients and mood and behaviour care and support care plans sighted evidenced interventions to support clients who are presenting with challenging behaviours over a 24-hour period.</p> <p>The outside environment provides easy access to different garden areas that enable clients to come and go safely. There are seating arrangements and different areas of focus.</p> <p>All families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The clients' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are client focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal specific to the client.</p> <p>Clients' changing needs are clearly documented in the care plans reviewed. Clients whose health status changes, and/or are not responding to the services/interventions being delivered, are discussed with their GP/NP and family. Short term care plans were sighted for wound care, infections, and changes in mobility, changes in</p>

		<p>food and fluid intake and skin care. The medical and nursing assessments of these short term care plans were documented in the client's progress notes. The health care assistants interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Families interviewed stated that they can consult with staff at any time if they have concerns or there are changes in their relative's condition.</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 two GPs and one NP who each visits the clients at the facility twice weekly and also provides after hours service which includes a full after hours medical on call service. The RN in discussion with the GP/NP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the client's file and were sighted. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The NP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</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>There are clearly described policies and procedures for the safe and appropriate disposal of waste, and infectious or hazardous substances. These comply with local government and legislative requirements, the requirements of this standard and the provider's contract with the DHB (ARC contract)</p> <p>Visual inspection and interviews with care staff, cleaning and laundry staff and their managers on the days of audit, revealed that chemicals were stored securely and that there is safe disposal of body waste and contaminated or potentially infectious products. Incontinence products are doubled bagged and bins are emptied to outside containers regularly. There are recycling and waste sorting procedures on site. The sluice rooms in each of the wings were exceptionally clean and well equipped. Personal protective equipment is available and was seen to be used on the days of audit.</p> <p>Staff interviewed demonstrated knowledge and understanding of safety issues around managing hazardous substances, including cytotoxic substances and sharps waste which is collected by external providers. Staff training records and interviews confirmed that all staff</p>

		are provided with initial education and then ongoing information, and support by the organisation and external chemical suppliers.
<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>The buildings are very well maintained, in good repair and fit for purpose. There is a current building warrant of fitness which expires in July 2017. Visual inspection of all internal and external areas revealed no environmental hazards. Interview with four health and safety representatives from different areas confirmed their vigilance in identifying, reporting and removing any potential risks to client safety.</p> <p>Interview with the facility and support services manager, review of records and observations on the days of audit showed that electrical testing and tagging is completed annually by a certified electrician, and calibrations of scales and medical equipment occurs as required by the device. Inspection of the equipment revealed that fire safety equipment and hoists are regularly checked for safety. All vehicles have a current warrant of fitness and registration.</p> <p>External furniture and walkways were viewed as safe for use by the client group and are being well maintained. Each building has access to outside sitting areas with protection from the elements.</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>A number of hospital bedrooms have individual toilet and shower ensembles, otherwise there are two bedroom shared toilets and additional bathing/shower facilities. In most instances staff are supporting clients with showering. Each wing has a sufficient number of showers for the number of clients in that wing. Additional toilets are conveniently located throughout each building. There are separate staff ablutions. There have been no reported issues with maintaining consumer privacy when attending to personal hygiene needs.</p> <p>Hot water monitoring is occurring monthly and temperatures are well within safe limits of below 45 degrees. The temperature of all hot water outlets is moderated by tempering valves. This was confirmed by hand testing of taps in various locations during the onsite audit. Hand washing facilities and gel sterilizer units are strategically placed throughout the facility for staff and visitor use. Clients and families interviewed were very happy with the facilities provided.</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>	<p>FA</p>	<p>Except for five bedrooms in the older part of the hospital wing which have four beds, all bedrooms have a single occupant in them. This was confirmed by visual inspection of all internal areas. The rooms are spacious and easily accommodate a bed, occasional furniture, chair and personal effects. There is enough room for residents to move around safely with or without a mobility aid. Clients and their families expressed satisfaction with their personal space. The service meets the requirement of the ARC contract and this standard.</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>	<p>FA</p>	<p>The three dining rooms and communal lounges in the hospital facility are within easy walking distance from client's bedrooms. The secure dementia unit and rest home/hospital wing have their own lounge and dining areas. There are additional sitting nooks and quiet rooms located in each building which may also be used for activities or visiting. Communal areas were decorated according to different themes to provide visual stimulation for clients and each building had a multi-sensory modulation (Snoezelen Therapy) room for use by clients who may benefit from time spent in these soothing and tactile environments. Adverse event documents and staff interviews reveal there have been no falls incidents related to clutter or placement of furniture. Staff report that all areas are inspected for hazards daily. Clients and family members interviewed expressed satisfaction with the layout of the facility, furniture provided and communal areas.</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>	<p>FA</p>	<p>Sufficient numbers of cleaning staff are allocated enough hours seven days a week to carry out these services. The laundry is staffed by four to five people who are on site six days a week. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Interviews and documents reviewed confirmed that where improvements can be made these are implemented (for example, there has been a change of chemical supplier to reduce the need for staff to handle chemicals). The household support supervisor is very experienced and provides ongoing support and education to staff about safe handling of the products in use. Current material safety data sheets about each product are located in close proximity to chemicals. Service improvements continue to be introduced to prevent staff injury and increase efficiency. Examples of this are the provision of pre</p>

		moistened floor mops to avoid the use of water filled buckets. There are very well planned and monitored work schedules for each area.
<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>The service has clearly documented emergency plans, and the emergency and security systems are well established and known by staff. There is an approved fire evacuation scheme. Fire drills are occurring every six months and staff attendance is monitored. Staff receive extensive information on emergency procedures at orientation and there is ongoing training about civil defence processes and keeping clients safe during emergencies (for example, the organisation conducts a new emergency disaster scenario and planning exercise each year).</p> <p>Review of staff training records and rosters and interview with the nurse managers, and Q&amp;D manager showed there were sufficient numbers of registered nurses on site and on call, seven days a week to manage emergencies.</p> <p>All clinical staff plus cleaners, activities staff and drivers are being supported to maintain certificates in first aid.</p> <p>Interview with the facility and support service manager and inspection of the emergency/civil defence stores confirmed there was sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster or power outage. There is 40,000 litres of water on site, and the facility has back up lighting and small generators that staff are trained to initiate.</p> <p>The call bell system was observed to be functional during the onsite audit and clients and families interviewed confirm that staff usually respond to call bells in a timely way.</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 main source of heating is via radiator panels that can be adjusted in individual areas. All internal areas were a comfortable temperature. Visual inspection revealed that all areas in each building has sufficient natural light from windows, doors or sky portholes. Each room has at least one good sized opening window for ventilation and there are external doors off many of the hospital and rest home bedrooms. Clients and families expressed satisfaction with the environment.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The facility has a documented infection control programme which is reviewed as part of the annual quality review of the whole quality programme. The infection control programme minimises the risk of infections to clients, staff and visitors to the facility.</p> <p>There is a dedicated registered nurse who is the infection control coordinator and who is a clinical nurse specialist in infection control. This person is accountable and responsible for following the infection control programme. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each infection control committee and staff meetings. If there is an infectious outbreak, then this would be reported immediately to staff and management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Clients with suspected and/or confirmed infections are reported to staff at handover and this is documented in the progress notes. The infection control coordinator is supported by clinical support nurses who, with the support of registered staff, identify and collate information related to residents with infections. Staff interviewed stated that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, shift handover and in client's progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, clients and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices found at entrances to the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and clients. Gloves and gowns were observed and found in all showers and toilets. Clients who have infections are encouraged to</p>
---	-----------	--

		<p>stay in their rooms if required.</p> <p>Infections and trends are discussed at staff meetings. Infection control education is planned on the educational calendar.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There is a dedicated registered nurse who is also a clinical nurse specialist in infection control and has the role of infection prevention and control coordinator. Infection control issues are identified to staff. Advice can also be sought from different external sources, including the laboratory diagnostic services and the GP/NP. The infection control coordinator regularly attends and facilitates infection control education both formally and informally (eg, 'tool box' sessions). The registered nurse and health care assistants interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise and reduce the risk of infections. This is supported by an infection control manual and policies and procedures that support specific areas including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management, cleaning disinfecting and sterilisation, waste management, construction and renovations. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The registered nurses and health care assistants interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing technique of staff is reviewed regularly by the infection control coordinator. Infection control in-service education and tool box sessions are held regularly and client and family education is provided, as and when appropriate. The infection control coordinator provides a monthly infection control memorandum to all staff which includes information about any national infection alerts or outbreaks and preventative measures to reduce and minimise the risk of infection. If an infection is identified for a client, an information fact sheet is also</p>

		provided to the client, family and staff as appropriate.
<p><b>Standard 3.5: Surveillance</b></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>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure clients' safety. The clinical support nurse from each of the three areas completes a daily report which includes clients with current infections. The infection control coordinator completes a monthly surveillance report. The service monitors urinary tract infections, influenza-like illness, common cold/pharyngitis, pneumonia, lower respiratory tract infections, skin, gastroenteritis, conjunctivitis and other issues, such as scabies and fungal infections. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in infection control committee, staff, and where appropriate, family meetings. Tool box education and information sheets are provided to clients, families and staff where appropriate. An external contractor benchmarks surveillance data quarterly with 75 other facilities.</p> <p>Six clients in June 2014 and three additional clients in December 2014 were diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA). In 2016, seven clients were diagnosed with a respiratory tract infection and in June 2016 four clients were diagnosed with conjunctivitis. The Public Health office was notified on the 14 September 2014 regarding a gastroenteritis outbreak. Sixteen clients and one staff member were affected. A plan was developed and health warning signs/communication were put in place. Cleaning, laundry and personal hygiene were emphasised. A corrective action plan was sighted meeting all legislation and standard requirements which included education.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The pre-audit document review of the service restraint policies showed they meet these standards and that the definition of an enabler is congruent with the definition in the standard.</p> <p>On the days of audit the restraint register listed four clients using bed rails and/or lap belts when sitting and two clients using bed rails as enablers. The register also lists 10 other clients who have bed rails</p>

		<p>raised on just the wall side of their beds to protect them from being too close to the wall radiators or an unavoidable gap between the wall and the bed. These eight records were not reviewed in depth but consent had been obtained from the clients for the single side bed rail. Client records contained evidence that assessment for use had been conducted prior to use, alternatives had been tried, approval granted by the restraint coordinators, nurse managers and medical officers and valid consent obtained by either the client or their welfare guardian/enduring power of attorney. There was evidence of ongoing monitoring and review for each restraint intervention.</p> <p>Training records and interviews showed that all staff attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year. Review of staff records showed all new staff are provided with information about the restraint policy, philosophy and approach during their orientation.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></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>Policy and procedures for restraint use and approval are clearly defined in the policy. The clinical support nurses in the hospital and rest home are the designated restraint nurses. These roles and responsibilities are described in policy. These include oversight of all restraint and enabler use, delivery of staff training and assessing staff competency along with support from medical officers, the Quality, Clinical and Ethical Committee and an external nurse consultant. The client risk committee meet monthly to consider all restraint matters. This committee is comprised of suitably skilled senior management clinicians, the three restraint nurses and the allied health service manager who is an occupational therapist and oversees physiotherapy services. The committee convenes monthly to consider restraint assessments, endorse approvals and monitor reviews and quality evaluations. There was clear approval for use of restraint on the records reviewed. Families are provided with an information pamphlet on restraint and enablers which clearly identify the risks associated with these.</p>
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Each of the client records reviewed for restraint use, contained a comprehensive account of the assessment made prior to use. These included current falls risk, a history of incidents, alternatives tried and reasons for the assessment being conducted. Any risks associated</p>

		with the bed rail or lap belt were identified and highlighted.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has succeeded in reducing the amount of restraint in use through the purchase of low low beds, sensor alarm mats and regular staff training. Records of restraint use show a steady decline each year (for example, there were 30 restraints in use for the same period in 2008, 23 in 2012, 15 in 2014 and now four in 2016). The alternatives considered and trialled before initialising restraint were documented in the restraint forms and in the care plans. The restraint nurse minimises as much as possible the use of restraint by educating and supporting staff to try alternatives and are continuing to seek new ideas. All staff must attend annual restraint training which includes a competency test. The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Documents, including care records, and staff interviews confirm that ongoing restraint use is appropriately evaluated and reviewed monthly by the client risk committee. Staff state they try different approaches to reduce restraint use and minimise unwanted behaviour. The restraint nurses maintain ongoing communication with families and support and encourage staff to trial new methods for keeping clients safe without the use of bedrails or lap belts. The service provider has complied with the requirements of this standard.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Quality reviews occur each month at the Client Risk Committee. Discussions and review includes considering the status, care and treatment of clients with challenging behaviour and all events related to this, monitoring how staff manage the events, and review of staff training needs. Six monthly audits of restraint use and practices, staff interventions and skills confirm that interventions are safe and effective and that strategies to reduce the use of restraint are succeeding.

## 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.

No data to display
--------------------

## 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 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Interviews with all levels of staff and consideration of the extensive written evidence from service monitoring and project outcomes demonstrate ongoing evaluation of the methods for gaining quality improvements and regular reviews of the progress against outcomes. One example of this is the Moving and Handling programme initiated in 2012. This project sought and obtained commitment and resourcing from governance and senior management at the outset, it required an inventory stocktake and replacement of equipment, the training of physiotherapy assistants as champions of the project, collaboration with the provider of bureau staff to ensure their training methods are aligned with CPT, a change to the way training was delivered (this is now twice monthly sessions with maximum nine participants to three trainers) and unique auditing</p>	<p>Quality and risk management processes are being continually reviewed and evaluated to determine if they are the most effective and efficient methods for monitoring and improving upon the services being delivered. Where required, new approaches are developed to target the areas of need and corresponding audit tools or other methods for assessing outcomes are implemented. Each year key areas for improvement are identified, following in depth analysis of the root causes and programme plans are developed. The progress of these plans is reviewed monthly by the teams involved and where change is required to expedite the desired outcomes these are added to the project plan. Each quality initiative is fully described with intended outcomes, why it is</p>

		<p>methodologies developed to assess the practical skills and capabilities of staff. There were significant milestones in the project such as an external enquiry into a client's bruising which was not investigated for three days. This and the results of other monitoring activities required immediate implementation of other initiatives whilst still progressing the project. Outcomes so far are downward trends in the number of reported client skin tears and bruising. This is significant considering that concomitant processes for validating these trends is occurring (for example, fortnightly 'head to toe' body checks of all residents by the RNs). The number of reported staff injuries has decreased from on average three per month to zero since April/May 2016. There have been no staff injuries requiring notification to Worksafe since 2014. The first observational audits of manual handling revealed 47% compliance with the tool and the most recent result is over 70%.</p>	<p>a priority and who is involved, a timeline for implementation and review periods, and the measures used for determining outcomes.</p> <p>The types of quality initiatives are site wide and multi layered (for example, improving the staff culture around training using a variety of new approaches, fire safety training for facility and support staff, keeping mobile clients with dementia safe from falls, introducing the use of aromatherapy oils in client care, reducing staff sick leave and turnover, moving and handling-as described above and an interRAI project). There is evidence that these projects and activities have resulted in measurable improvements to client outcomes and satisfaction.</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>CI</p>	<p>Interview with the Quality and Development Manager, review of the content of the revised orientation programme and cross referencing to the New Zealand Qualification Authority (NZQA) website and corroboration of communication with Careerforce confirms that this external training organisation have evaluated and moderated the new orientation programme and confirmed it is now linked to the NZQA framework. Completion of the programme by new staff results in that person attaining level 2 qualification with the Health and Wellbeing unit standards.</p>	<p>The service provider has recently revised its orientation programme and self-directed learning package for all new clinical staff (RN/EN/HCA) to align it with the Health and Wellbeing level 2 NZQA qualification. This has been moderated and endorsed by Careerforce. All new staff who complete the orientation programme within the prescribed three to six-month time frame will attain these unit standards. The changes to the orientation programme are linked to other organisational projects (for example, alignment of staff training, and improving staff performance) which aim to ensure all staff are skilled and competent to provide safe, best care for clients. So far the internal reviews and audits of client care (for example, evidence of decreases in client</p>

			skin tears and bruising) and reviews of staff competency assessments and attendance at training are revealing the positive trends desired.
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Review of staff training records shows a significant increase in attendance at regular and ongoing in house training. This has led to increased staff satisfaction as shown in the results of the 2015 to 2016 staff climate survey, and a decrease in formal disciplinary processes confirmed by interview with the GM. The percentage of HCAs completing NZQA unit standards has increased. Interview with five staff who have developed and delivered the tool box sessions, review of the participant's feedback and interviews with 27 staff in total revealed enthusiasm and loyalty to the organisation.</p>	<p>A multi-pronged approach to reinvigorating staff training has contributed to improvements in staff skills, competency and work ethic and decreased time spent in disciplinary processes and back filling staff absences. The organisation has invested heavily in getting staff trained to deliver customer service and communication sessions (for example, it pays for staff to attend compulsory training and remunerates an annual amount to staff who are committee members). One of the key drivers to 'switching on' staff attendance has been the development and presentation of 'educational toolboxes' by expert staff to the staff in their areas. These specific toolboxes presented by clinical support nurses, the catering supervisor, household services supervisor, health and safety officers, physiotherapy assistants and other expert staff, are popular with all levels of staff according to the feedback from participants. Another innovation in workforce development has been the three year roll out of 'Tetramap' training to teach empathy and understanding with clients, improve communication skills and empower staff to speak up and deal with conflict in healthy ways. This strategic initiative has been formally evaluated by the organisation and outcomes continue to be evaluated by the Clinical Management Team (CMT), GM and the board.</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>CI</p>	<p>In April 2013 the service discussed the need to implement interRAI due to the ADHB signalling they were no longer going to complete interRAI assessments from the 1st July 2014. Two registered nurses were recruited to complete interRAI assessments for all clients within 21 days of admission. It was established in discussing with the interRAI project managers that each interRAI assessment would take five hours in its entirety per client.</p> <p>A second project was initiated to ensure that all staff understood the interRAI assessor's role and not only the information required to complete an interRAI assessment but the outcome scores/'triggered caps' to ensure that staff who are completing/developing the paper based care plans captured the correct and appropriate information/data gathered in the interRAI assessments. Ongoing education has been provided to the registered staff to ensure that all relevant information from the interRAI is transferred to the paper based care plans and any information that has been found missing when the client has been reviewed or reassessed is then updated. Initially the assessments which include the gathering of information, meeting with different staff, the client and the family and the actual completing of the interRAI assessment in the database was taking 10-11 hours to complete. With ongoing training and support of staff in this transition the average time taken is now five hours. To also ensure ongoing communication once an interRAI assessment is completed the assessor will send an email to the clinical support nurses, copying in the Quality and Development Manager and nurse manager notifying update and any concerns. At the time of audit all clients have had a completed interRAI assessment within the</p>	<p>The service is rated a continuous improvement by demonstrating positive outcomes with the way that education has been initiated and developed in response to staff's understanding of the interRAI and timeframes in completing the assessment in its entirety and within timeframes meeting the DHB contractual requirements.</p>
--	-----------	--	---

		required DHB timeframes. Families interviewed state that the staff know their relatives very well and information gathered is discussed at time of initial care planning and reviews. The transfer from one service level of care to another when required occurs quickly and within appropriate timeframes and communication is of a high standard.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	CI	<p>The service has initiated several quality improvements since 2014. One of these initiatives includes Essential Oil therapy for aged care, dementia and end of life. There is a new policy/procedure and treatment and evaluation form. There is a monitoring system to look at effectiveness of oil blends. Other initiatives include; staff training an orientation (see criterion 1.2.7.3 and 1.2.7.5), wound care management planning, moving and handling quality improvement, fire safety training, developing planned advance care pathway to enhance client care, understanding clients with dementia, and safety of mobile clients with dementia.</p> <p>To meet the new ACC guidelines, the service developed the moving and handling quality improvement. A client risk committee was developed which reports to the clinical management team who in turn provides the board reports. Specific staff were trained to be 'on the floor' champions and formal training was provided for all staff in their individual respective roles and teams. Formal training of staff has since been reviewed due to feedback from staff suggesting that the learning groups are to big thus small group teaching sessions now occur. Senior management were involved to ensure understanding and that staff were supported and resources were available for staff and clients. A review of the environment was completed to insure uncluttered storage,</p>	<p>The service is rated continuous improvements in the moving and handling and wound care management quality improvements demonstrating positive outcomes with the way that education has been initiated and developed.</p>

		<p>accessibility of equipment and space to operate equipment. Physiotherapy assistants completed an initial moving and handling audit in June/July 2016 with a 47% staff compliance. The audit was repeated in September of 2016 with 70% staff compliance. Two ongoing training sessions occur for all staff and as an outcome of the equipment review, further equipment has been provided and implemented. Staff including bureau staff are also required to complete regular self-assessments.</p> <p>In February 2015 Caughey Preston initiated a quality improvement plan in wound care management to ensure that the service provided systems and processes that are reflected in evidenced best practice and commitment and excellence. Five registered staff in 2016 attended training through the DHB and are now acknowledged as 'wound champion' nurses. Significant wound care management training and education was implemented for all staff which included education around the new wound assessment, care and support plans and monthly wound logs that were developed. An informed consent form was developed to support photos taken of client's wounds. A wound care competency audit tool was also developed and all results were reported on a monthly basis to the newly formed wound care group and staff meetings. As a result, a wound care competency audit was implemented in June 2016 with a 75% staff compliance. Staff throughout the audit were given the opportunity to provide verbal feedback of their experience, the overall response being that the staff felt more knowledgeable around wound management and documentation. The audit findings also acknowledged that further actions still need to be explored which include reminding registered nurses to replenish stock after each use</p>	
--	--	---	--

		and continue to provide ongoing education specifically as new situations/wounds arise, which is currently being planned. Families interviewed stated that communication from staff was of a high standard. The NP stated that staff strive to meet best practice. Evidenced at time of audit was a letter stating that the specialist having seen the client was impressed with the standard of documentation, wound dressing, planning, knowledge and support provided by staff at Caughey Preston.	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Six clients in June 2014 and three additional clients in December 2014 were diagnosed with Methicillin-resistant Staphylococcus aureus (MRSA) in one of the three units. As a result of these findings the infection control co-ordinator in discussion with external support and clinical microbiologist identified that the outbreak was due to poor compliance with hand hygiene. Hand hygiene education was completed which included a visual hand washing audit of this unit resulting in staff achieving a compliance result of 55%. As a result of the additional cases being identified and extra precautions activated again the '5 moments of hand hygiene' audit was developed and implemented which includes focus not only on hand hygiene but the availability and utilisation of personal protective equipment by staff. Several audits were completed over the following months with varied results, resulting in further education, new equipment (hand gel dispensers), and staff were encouraged to ensure that all protective equipment and resources were restocked regularly in all areas and utilised. The '5 moments of hand hygiene' audit in May 2016 had a compliance of 37%. Following further discussions with staff the audit was again completed achieving compliance of 100% for handwashing. In regards to stocking</p>	<p>The service is rated a continuous improvement by demonstrating an increase in compliance of handwashing and as at the time of audit having no further identified cases of MRSA.</p>

		of equipment the audit findings were 73.5%. At time of audit there have been no further cases of MRSA identified within the unit. Ongoing education continues and is discussed at all relevant meetings.	
--	--	--	--

End of the report.