

Cambridge Resthaven Trust Board Incorporated - Cambridge Resthaven

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Cambridge Resthaven Trust Board Incorporated
Premises audited:	Cambridge Resthaven
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 27 September 2016 End date: 28 September 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	76



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

Cambridge Resthaven is a community trust aged care service that provides rest home, hospital and secure dementia level of care for up to 92 residents. At the time of audit there were 76 residents (28 hospitals, 31 rest home and 17 living in the secure dementia unit), these numbers include four younger people under the age of 65.

A certification audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board. The audit process included an offsite and onsite review of documentation, observations and interviews. Interviews were conducted with governance, management, clinical and non-clinical staff, residents, family/whanau and a general practitioner to verify the documented evidence.

There is one area of required improvement identified at this audit related to the level of documentation of the care evaluations. The strengths of the service include the implementation of the quality projects, specifically related to gaining increased outcomes in the quality of life of residents, this has gained an excellence rating (continuous improvement).

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and their families are informed of their rights at admission and throughout their stay. Available throughout the facility are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service.

Residents receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs.

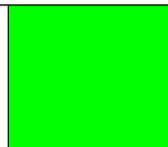
Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. The advocacy service visits regularly for staff education and attendance at residents' meetings.

The resident and families report the service has an easy to use complaints management system. There is a complaints register that contains any complaint received and actions taken to address any shortfalls

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

The service is a community charitable trust. The mission, vision and direction of the service is clearly dominant in strategic and governance records. Cambridge Resthaven has a documented and implemented quality and risk management system that supports the provision of clinical care and support. The service uses an international business excellence framework in their strategic planning and quality system implementation.

The general manager is suitably qualified and experienced to run the service. The general manager reports to the chief executive officer, who reports to the Board of Trustees. The general manager is also supported by the clinical and non-clinical members of the management team.

Policies are developed by an external consultant and are reviewed by the management team annually. The quality and risk performance is reported and monitored by the management team. Review of service delivery in the quality systems includes incidents/accidents, infections, complaints and reports from the internal audit programme. Key performance indicators are developed and based on the internationally recognised quality business excellence framework to match the business plan. These are reported and measured as identified on the care and processes matrices, balanced score card and external benchmarking.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the residents' needs at the various levels of care. The education programme for all staff is available and planned for the year.

The confidentiality of resident's record is maintained. There is no private information on public display.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and implemented in a timely manner. Documented interventions are sufficiently detailed to address the desired goals/outcomes. Improvement is required in relation to evaluating the resident's goals/desired outcomes. Short term care plans are consistently developed when acute conditions are identified. Planned activities are appropriate to the needs, age and culture of the residents who reported that the activities are enjoyable and meaningful to them.

The medicine management system meets the required regulations and guidelines.

Food services meet the food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met. Reviewed resident files evidenced stable weights and interventions are in place when weight changes are identified.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment.

The environment is appropriate for rest home/hospital and specialist dementia level of care services. All areas ensure physical privacy is maintained and have adequate space and amenities to facilitate independence.

There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

The facility has an appropriate call system installed. There is easy access to external gardens, grounds and court yards for residents and their visitors. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. The secure dementia unit is separated from the rest home/hospital sections.

Routine safety checks and internal audits are performed by maintenance personal and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures identify the safe use of restraints and enablers which are used as the least restrictive option that allows the residents to maintain independence, comfort and safety. Risk management plans are in place to prevent restraint-related injuries. There are no residents on restraints and 16 using an enabler. Staff trainings on restraints and enablers are conducted annually. Interviewed staff demonstrated good knowledge on restraints and enablers. The restraint register is current.

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.

Infection control prevention and control policies and procedures include comprehensive infection control programme in order to maintain low infection rate in the facility. The infection control coordinator collates and analyses monthly infection control data. The type of surveillance is appropriate to the size and complexity of the service. The infection rates are discussed in the monthly staff meetings and interventions to reduce the infections are discussed.

Infection control experts are available and can be consulted when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff (e.g., staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the resident's rights and respect these when interacting with residents.</p> <p>The residents reported that they are treated with respect and understand their rights. The families reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated. The files reviewed of the residents living in the dementia unit confirm processes are implemented to gain information and involve the EPOA in the residents care and service delivery. The rest home and hospital residents' files reviewed confirmed</p>

		<p>the resident and, as appropriate, family involvement in care decisions.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. An advance directive and advance care planning includes the resident choices for end of life care. The files reviewed had signed advance directive forms which meet legislative requirements, and staff demonstrated knowledge on how to act on the information in these.</p> <p>Residents, and as required, families are actively involved and included in care decisions as evidenced in residents' files reviewed.</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>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons. This was confirmed in interview with residents and families.</p> <p>Education from the Nationwide Health and Disability Advocacy Service is undertaken as part of the in-service education programme. The staff report knowledge of residents' rights and advocacy service.</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>	FA	<p>Residents reported they are supported to be able to remain in contact with the community by outings and walks to local shops and parks. Policy includes procedures to be undertaken to assist residents to access community services and a van is available. There is a portable phone which is taken to the residents as required.</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>	FA	<p>The general manager is responsible for complaints and there is a system in place to manage the complaints process. The complaints policy and procedure meet the requirements of Right 10 of the Code. Complaints forms are accessible in different localities around the facility (including the dementia unit) and at reception. The policy is displayed on the notice board to guide staff.</p> <p>There is a complaints and compliments folder (referred to as the 'pink slip' system). The complaints register contains all complaints, dates and actions taken. The complaints sampled for 2016 record that these are dealt with within times frames of Right 10 of the Code. There were no external complaints at the time of the onsite audit. Residents and families interviewed demonstrated an understanding and awareness of the right to make a complaint.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families (as confirmed by interview with the staff). Discussions relating to residents' rights and responsibilities take place formally in staff meetings and training forums and informally with the resident in their room. Education is held by the Nationwide Health and Disability Advocacy Service as part of the ongoing education programme.</p> <p>Residents are addressed in a respectful manner and by their preferred names, as confirmed in interview with residents and families.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed. Staff demonstrated knowledge of residents' rights and understand dignity, respect and identifying abuse and neglect. As observed, the support and services provide in the specialist dementia unit are provided in a flexible manner that focus on minimising of challenging behaviours without the use of restraint.</p> <p>The residents and families had no concerns regarding abuse or neglect, how they are treated by staff, all had high praise for the 'quality' of the staff.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included and cultural safety competence is part of the ongoing education programme. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. There were no residents who identified as Maori in the service at the time of audit. There are no known barriers to Maori accessing the service. The staff gave examples of previous residents who identified as Maori and the culturally appropriateness of the care and support provided to these residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>The nursing staff assess the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's</p>

<p>services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>individual needs.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided as confirmed in interviews with hospital and rest home residents and dementia unit relatives, and review of satisfaction surveys.</p> <p>Staff interviewed reported on the need to respect individual culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position description, code of conduct and expected standard of behaviour documents sighted in staff files outlines professional boundaries. The staff verbalise they would report any inappropriate behaviour to the general manager (GM). The GM reported they would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents and families indicated no concerns.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services. There is regular in-service education and staff access external education that is focused on aged care and best practice. The service has implemented specific best practice and evidenced based programmes for pressure area prevention, wound management and innovations is supporting resident's quality of life (refer to 1.2.3.5 for the excellence rating). The services have contributed to a district health board (DHB) project on wound management in aged care facilities.</p> <p>Staff reported that they were satisfied with the relevance of the education provided. The residents, families and GP all expressed high satisfaction with the care delivered. Particular praise for the knowledge, skills and best practice expectations of the general manager and clinical manager were expressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents, who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. These can be contacted via the DHB or interpreting</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>services (including sign language). There are a number of staff from different cultural and linguistically diverse backgrounds and they can assist in interpreting if required.</p> <p>Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The incident reporting processes evidence open disclosure. The families indicated when and what type of incident/accident/change in condition they would like to be informed about. Staff make adequate time to talk with residents and families. The staff reported that since the induction of the Namaste philosophy (refer to 1.2.3.5), they have been able to spend increased time in meaningful conversations and interactions with residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service is planned to meet the needs at the younger and older residents at rest home, hospital and secure dementia level of care. The care facility is set within a retirement community/village. The aged care facility has maximum of 92 residents. There is a 20 bed secure dementia unit, one 4 bed wing that is solely rest home and 56 dual purposes beds (either rest home or hospital level of care). There are an additional 12 apartments that are attached to the rest home/ hospital wings, though these do not currently have any resident assessed as requiring rest home level at care. At the time of audit there were 76 residents (28 hospitals, 31 rest home and 17 living in the secure dementia unit), these numbers include four younger people under the age of 65, plus the 12 people in the apartments.</p> <p>The service is a community trust, with the board of seven trustees providing the overall governance structure. The service is also part of another community charitable trust with other aged care services that provide collegial and other support to each other. A board member of the Resthaven board is on the wider community charitable trust board.</p> <p>There is a five-year strategic plan (2013-2017), that has an annual review. The board meet monthly to review the ongoing organisation performance against the key performance indicators identified in the strategic plan. The service uses an international excellence quality framework in their strategic planning, policy development and the quality improvement programme.</p> <p>There is a chief executive officer (CEO) who is a registered nurse (RN) with management qualifications, and is employed by the board for the management of the whole retirement village complex. The CEO reports to the board monthly and has meetings with the chair of the board. The management of the aged care facility has been delegated to the general manager. The general manager reports to the CEO.</p> <p>The general manager is an appropriately experienced and qualified registered nurse. The general manager's job description describes their roles, responsibility and accountability for the provision of</p>

		<p>service in the care facility. The service is a member of an aged care association and receives updates on issues related to the management of an aged care facility. The general manager has attended over 8 hours' education related to aged care management in the past 12 months.</p> <p>The residents and family/whanau interviewed and satisfaction surveys report satisfaction with the quality of care and services provided</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The CEO, clinical nurse leader or another RN (trained as part of the succession planning process) take on the management roles when the general manager is on leave. The general manager reports confidence in the management team to take on the general manager's role during their temporary absence.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The staff and members of the management team demonstrated an understanding of the quality and risk processes that are identified in policy. Staff at all levels of the service report their involvement with the ongoing quality and risk management systems. Staff stated that quality improvement was a team effort, they had increased their knowledge in this area, and that they had a better understanding of quality and risk and the significance for gaining better outcomes in care and service delivery.</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at least two yearly. The policies are developed by an external consultant and reviewed by the appropriate team member to ensure they are reflective of best practice and reflective of Resthaven practices, approaches and philosophy.</p> <p>The internal audit system is used to ensure all components of service delivery compliment the quality management system. The internal audits are conducted as planned in the audit schedule as well as internal audits being conducted 'ad hoc' to address any specific issues. The action sheet that is part of the internal audit records the outcome of the audit, compares to the previous audit, makes recommendations for implementation, then records the actions to address any shortfalls identified. Internal audits were sampled for 2016, which confirm the services processes are implemented.</p> <p>The service has systems implemented for quality management, the collation and analysis of data, and processes to measure achievement against the quality and risk management plan and</p>

		<p>strategic directions. Monthly surveillance is collated, benchmarked and reviewed by the management team. Benchmarking occurs with internal, national and organisational targets. Data is trended and results presented at staff and management meetings. The service has set key performance indicators that are linked to the business plan and strategic direction. The general manager provides a written report to the board on how the service is performing in the key components of service delivery.</p> <p>The service has conducted a number of opportunities for improvements (OFI) plans and were able to demonstrate that these are leading to increased quality of life for the residents (refer to 1.2.3.5), particularly in the project related to Namaste programme. The information related to quality systems is covered at staff meetings, as confirmed in the meeting minutes sighted. Monthly combined staff, quality and health and safety meetings have trended data and benchmarking results presented as part of the standing agenda. Meetings are used to review corrective actions put in place.</p> <p>The organisation has an up to date risk register and quality and risk plan which identifies actual and potential risks for all levels of service. Minimisation strategies have been put in place as required. Staff education includes risk management processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of pressure injuries stage 3 and above. The general manager reports that there have been two fractures and a medication error in which the appropriate authorities were informed or contacted for further advice.</p> <p>The number of incidents are collated on a monthly basis. Samples of incident/accident forms and the trended data were reviewed. Any trends identified are notified and information fed back to the board, committee meetings, staff meetings and the coaching and mentoring sessions. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident's care plan as required.</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</p>	<p>FA</p>	<p>All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APC and competency assessments are due. Copies of APCs were sighted for all staff who require them.</p> <p>Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. There are at least annual performance reviews for the staff, where training or shortfalls in staff performance or achievement of goals/outcomes are</p>

<p>legislation.</p>		<p>identified, support and coaching sessions implemented to assist staff achieve their desired outcomes throughout the year.</p> <p>Training needs are identified in the annual performance appraisal process, through review of monthly quality data and staff mentoring and coaching sessions. Mandatory training to meet contractual obligations is two yearly, or more frequently for such topics as infection control and restraint minimisation and safe practice. The care staff, activities, kitchen and housekeeping staff are supported to gain appropriate national qualifications if they do not already have them. The education schedule reviewed for 2016 year has content and variety and meets all obligations of the provider's residential care contract with the district health board and to meet the standards (including infection prevention and control and restraint minimisation). There are adequate number of RNs who are interRAI competent. The activities staff (diversional therapists) have completed specialist education and training in dementia care.</p> <p>The staff who work in the dementia unit (including registered nurses) are required to undertake the national standards in dementia care. All staff have either completed or for new staff (under three months of employment) are in the process of completing the required education. There is an additional orientation process for the staff who work in the dementia unit. This orientation/induction includes the specific needs of the residents, including, behaviour management, de-escalation and implementing activities and therapies.</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>Staffing levels are based on the safe indicators for aged care and dementia care. The general manager reports that the allocation and skill mix of the staff is reviewed and audited (internal audit sighted) six monthly to ensure the safe staffing levels are achieved. The current roster sighted for the rest home, hospital and dementia unit indicated they exceeded the minimum requirements.</p> <p>A review of rosters identified sick leave and annual leave is shown and replacement staff noted. There are sufficient numbers of laundry, housekeeping, activities, support and administration staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member's name and designation. The residents' files reviewed evidence that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records.</p>

		All residents' files reviewed showed evidence of completed interRAI assessments.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy and procedures provide guidelines when a resident is admitted. Admission agreements are signed by the residents or by their families and the provider. This was discussed in detail with the resident or with families by the general manager or CEO. Interviewed residents and families confirmed that they had the opportunity to discuss the admission agreement with the general manager.</p> <p>Residents in the dementia unit have been assessed for specialist dementia level of care. Families are informed about how challenging behaviours are managed in the unit.</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>A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or to another provider. Other relevant documents are included in the transfer (yellow) envelope. The clinical nurse leader reported that verbal hand overs are conducted for all transfers to other services. The resident's current interRAI assessment summaries are provided to ensure continuity of care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>A medicine management system is implemented to ensure safe delivery of medicines to the residents. Medication charts have photo identifications, allergies are documented and indications for both regular and "as required" medications are documented. Medication records are reviewed three-monthly. Weekly and six monthly controlled drugs stocktakes are conducted. The controlled drug register was correct and current.</p> <p>The medicine fridge temperature is monitored and recorded regularly.</p> <p>Medication reconciliation is conducted when residents are discharged back to the service and actions are in place when variance are identified. A system is in place in returning expired or unwanted medications. There were no expired medications and all medications are stored appropriately.</p> <p>The staff administering lunch time medications complied with the medicine administration policies and procedures. Current medication competencies are evidenced in the staff records.</p> <p>There was one resident who self-administered medications. Policies and procedures are in place to ensure safe storage and compliance to requirements and the RNs ensured that these are followed in practice.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is contracted to an external agency. Policies and procedures include food safety, ordering, storage, cooking, reheating and food handling. A system is in place in receiving and utilising supplies. All meals are cooked onsite. Staff working in the kitchen received an induction programme and all have current food handling certificates. The kitchen staff use safe food handling practices when preparing meals. Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary forms are completed by the admitting RN and the kitchen is provided a copy. Additional or modified foods are also provided for the residents.</p> <p>Fridge, freezer and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the main dining area while meals for the other dining areas and dementia unit are transported in an insulated trolley. There are bain marie's in use to ensure that meals are served warm.</p> <p>The meals were well-presented. Interviewed residents confirmed that they are provided with alternative meals when required. All residents are weighed monthly and residents with weight changes are either provided with food supplements or smoothies. Additional nutritional foods are available to the residents over the 24-hour period. The chef also reported that they provide fortified foods as per instruction by the RNs.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is a policy on declining entry to service. There are processes in place when a resident is declined from entry to the service. Potential residents are referred to other nearby providers when needed. The general manager reported that the needs assessors from the district health board provide the service with completed level of care assessments to ensure the suitability of the potential resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The registered nurses (RNs) admit residents using standardised risk assessment tools. Individual assessments are sighted in relation to personal needs, behaviour and recreational requirements of residents. Residents are assessed using the interRAI assessment tools within the required time frames. There are six interRAI competent staff conducting interRAI assessments. Trends are generated after completing interRAI assessments and these are all addressed in the reviewed long term care plans.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long term care plans are resident-focused and personalised. There is evidence that the service promotes continuity of care and the goals are specific. The RNs develop and implement long term care plans. A 24-hour management plan is in place for all residents in the dementia unit and behaviour management plans are in place for residents with challenging behaviours. Short term care plans are developed when acute conditions are identified. Residents and families are involved in the development of the long term care plans. Staff are informed regarding changes in care plans through hand overs and monthly staff meetings.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and healthcare assistants follow the care plan and report progress against the care plan in each shift during handover. Documented interventions are sufficiently detailed to address the desired goals/outcomes. Short term care plan interventions addressed the issues identified when a resident developed an acute condition.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. Individual activity plans sighted reflected the residents' preferred activities gathered during the interview with the residents and families. The service commenced a programme called "Namaste" which involves one-on-one activities with the residents when they are unwell on not participating in activities. Residents with cognitive impairment are provided with one-on-one activities as well. A participation log is maintained. An individual 24-hour activity plans are in place for all residents in the dementia unit.</p> <p>There are two diversional therapists (DTs), one of which develops the annual activity programmes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Short term care plans are developed and evaluated in a timely manner and the resident's response to the treatment regime is documented. The diversional therapists evaluated the activity plans every six months or more frequently when required. There was no evidence that the resident's goals in the long term care plans are evaluated to indicate the degree of achievement in relation to the interventions in place.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	<p>FA</p>	<p>There are documented policies and procedures in relation to exit, transfer and transition of residents. There was evidence that residents were referred by the GP or by the RNs to other</p>

<p>(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>		<p>specialist services. Residents and families are kept informed of the referrals made by the service. Internal referrals are facilitated by the clinical nurse leader. Interviewed staff confirmed that they can refer residents to the physiotherapist when residents have changes in mobility or to a dietitian when weight changes are identified.</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>	<p>FA</p>	<p>The waste management policies are effectively implemented. The contracted cleaning company also has a cleaning, technical and operations manual that meets the requirements of the standards. Staff receive training and education on waste management and the handling of hazardous substances. Personal protective equipment (PPE) is available and observed to be used appropriately. Chemical safety data sheets are located where chemicals and hazards substances are stored. The staff demonstrated knowledge on the use of PPE, safety data sheets and the handling of waste and hazardous substances.</p>
<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>	<p>FA</p>	<p>The building warrant of fitness expires in May 2017. There is a planned maintenance schedule as well as a reactive maintenance programme to new issues that may arise. Medical equipment (including hoists) are calibrated annually, with these last being conducted in November 2015. The electrical equipment evidenced test and tag labels, testing last conducted in May 2016.</p> <p>The facility is fitted with hand rails that assist with mobility. The corridors are wide enough for residents and their mobility aids. There is access to external areas and courtyards. The secure dementia unit has areas that are designed for residents to wander freely.</p> <p>The residents and families reported satisfaction with the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The facility has a mix of ensuite and communal use toilets and showers. Communal facilities are conveniently located in each of the wings that do not have ensuite facilities. The communal facilities have appropriate signage and privacy signage. The residents and families reported satisfaction with the access to and privacy of toilet and shower facilities.</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>There are two shared rooms, with all other rooms being single occupancy. In the shared rooms there is privacy screening and enough space for each of the residents. The staff, residents and families reported overall satisfaction with the space in each of the rooms.</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>Each of the wings have dining, lounge and entertainment areas. The dementia facilities are separated from the rest home/hospital sections of the service. There are additional larger and smaller rooms for entertainment or quiet activities. The residents and families reported satisfaction with 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>The laundry services are conducted offsite by a contracted company. There are appropriate processes to maintain a dirty to clean flow of the laundry and the returning of clothing to the residents. The laundry processes are monitored through in the internal auditing system and satisfaction surveys.</p> <p>The cleaning is conducted by contracted staff. The cleaning trollies are securely stored when not in use. There is a monthly site inspection by the company to monitor the effectiveness of the cleaning processes.</p> <p>The residents and families reported satisfaction with the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The approved evacuation scheme is dated 17 September 2014. Staff receive training at orientation and as part of the ongoing education programme in responding to emergency and civil defence situations. Evacuation drills are conducted six monthly, with the last one being conducted July 2016 (trial evacuation report sighted). In an emergency there is back up gas for cooking and heating. The service is fitted with emergency lighting, the civil defence kits sighted have emergency supplies. The service has an arrangement with an external organisation for the supply of drinking water in an emergency, with access to stored water also available onsite.</p> <p>There call bell system includes audible and visual alerts, a light comes on above the resident's door and there is a central display panel to alert staff as to the room that has rung.</p> <p>A security company conducts night time security rounds of the perimeter of the building. The</p>

		afternoon and night staff lock external windows and doors as part of their rounds.
<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	All resident areas are appropriately heated and ventilated, with at least one external window/sliding door in resident areas for natural light and ventilation. The residents and family reported satisfaction with the light, heating and ventilation.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>One of the RN is the designated infection control coordinator. The responsibilities of the infection control coordinator (ICC) are clearly defined which includes collating, analysing and trending the monthly infection rates. Infection rates and ways to reduce infections are discussed in the monthly staff meetings as well as in the clinical meetings and weekly debriefs in the units. The service utilises the support of an external infection control expert as well as the infection control nurse from the public hospital.</p> <p>The infection control programme is reviewed annually.</p> <p>Residents and families are encouraged not to visit when unwell. There are adequate hand basins for the staff, residents and visitors to use.</p> <p>Infection prevention and control policies and procedures are readily available for the staff in the main rest home & hospital nurses' station where the staff working in the dementia unit can access these policies and procedures.</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	The ICC with the support of another RN are responsible in facilitating infection prevention and control activities in the facility. They are responsible in implementing and evaluating the effectiveness of the infection control programme. The GP reported that RNs contact the medical centre when residents developed acute conditions. An external infection control expert provides advice to the ICC. Staff demonstrated knowledge in preventing the spread of infection and outbreak management.
Standard 3.3: Policies and procedures	FA	There are documented policies and procedures for the prevention and control of infection in the facility. Sighted policies align with the current accepted good practice and relevant legislative

<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>		<p>requirements. Policies are readily available for the staff and procedures are simple, practical, safe and suitable for the type of service provided. Best practice is reflected in their everyday service delivery. Infection prevention and control policies and procedures are reviewed annually.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection prevention and control education is provided to staff during orientation and as a component of their ongoing education programme. The ICC and the support RN attended annual infection control update. Residents and families are provided with advice in relation to infection prevention and control activities. Staff demonstrated knowledge on infection prevention and control as well as outbreak management.</p> <p>Education record regarding infection and control in-service trainings is maintained by the ICC.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for infection rates is carried out in accordance with agreed objectives and methods in the infection control programme. Surveillance activities are appropriate to the size and setting of the service. Infection rates are monitored, collected and analysed by the ICC. Infection rates are discussed in the monthly staff and clinical meetings as well in the weekly debriefs in the units. Recommendations to reduce, manage and prevent the spread of infections are discussed as sighted in the meeting minutes.</p> <p>The service benchmark their monthly infection rates with other providers.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service demonstrated that the use of restraint is actively minimised. There were no residents using restraints and 16 residents using enablers. The restraint/enabler register is current and updated. The policies and procedures have clear definitions of restraints and enablers. Staff knowledge regarding restraints and enablers as well as the risk management plan in place to prevent restraint or enabler-related injuries.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Short term care plans are evaluated and the resolutions of the acute conditions are documented.</p> <p>Nine of nine resident files reviewed had no detailed documentation of the evaluation of goals and progress towards meeting desired outcomes.</p>	<p>There was no evidence that residents' goals/desired outcomes are evaluated and the residents' response to the interventions to achieve the desired outcomes are not detailed.</p>	<p>Provide evidence that resident's goals/desired outcomes are evaluated.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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>The service has conducted a number of quality improvement projects in 2015 and 2016. Some of the projects sampled are related to wound management, the resident model of care (Namaste) and a benchmarking programme. Each of the opportunities for improvement plans have measurable improvement indicators. Resident satisfaction is measured as part of the review, which includes resident and family satisfaction and achievements against benchmarking and the measurable improvements indicators. The reporting of the analysis and outcomes of the project are presented to the board of trustees, quality meetings, staff meetings and residents’ meetings.</p> <p>The review of the Namaste – Quality of Life project was developed for staff to spend quality time with residents who could no longer participate effectively in the activities programme or who could no longer communicate verbally. The project included reporting of the measurable improvement indicators. The results of the project and ongoing implementation record positive outcomes (through satisfaction surveys</p>	<p>The achievement of the quality projects and quality management systems is rated beyond the expected full attainment. The quality improvement projects, in particular reference to the Namaste philosophy, have a documented review process which includes analysis and reporting of findings to management, the board of trustees, staff and residents. The projects documentation evidences action taken based on findings and improvement to service provision. Resident and family satisfaction have been measured, through family feedback, as a result of the review process</p>

		and feedback from families). The staff report that the Namaste philosophy has provided them with greater opportunities to spend individualised quality time with residents and they are seeing outcomes for residents including falls reduction and increased happiness (singing and smiling). The residents and families reported that the staff spending time, and how they are communicated with, is a strength of the service.	
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End of the report.