

Avonlea Trust Board - Avonlea Hospital and Home

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:	Avonlea Trust Board
Premises audited:	Avonlea Hospital and Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 November 2016 End date: 24 November 2016

Proposed changes to current services (if any): Since the last audit the service has reconfigured the use of some rooms. The number of dual purpose beds (rest home or hospital level of care) has been increased from eight to 17, which has reduced the rest home only level of care rooms from 34 to 25. The change was assessed by the MoH as low risk and a partial provisional audit was not required.

Total beds occupied across all premises included in the audit on the first day of the audit: 44

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

Avonlea Trust Board provides rest home and hospital level of care for up to 50 residents. There were 44 residents at the time of audit. Residents and families reported satisfaction and were positive about the care and services provided.

This audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included an onsite audit and review of resident and staff records, observations and interviews. Interviews were conducted with residents, families, management, clinical and non-clinical staff and a general practitioner (GP).

There are three shortfalls identified related to the analysis of quality data, medication management and monitoring of food temperature. No other systemic issues or shortfalls were identified.

Consumer rights

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

Residents receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed to ensure they receive services that respect their individual values and beliefs, including for those residents who identify as Maori. There are processes to access interpreting and translating services as required.

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 sampled. There were advance care plans and advance directives that record the residents wishes, with these respected by staff.

There is a documented complaints process that complies with the Code. There were no outstanding complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A business plan and quality and risk management plan is documented and includes the mission and goals of the service. There is a process in place for the regular reporting against these goals.

The organisation is managed by an experienced and suitably qualified facility manager, who is a registered nurse. The organisation is governed by a board of trustees. The service is also part of a wider community trust board along with other smaller rural providers across the Waikato.

Quality management data is collected and discussed at staff meetings and staff were able to describe this. There is an internal audit programme. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of improvements implemented based on the findings. Open disclosure is documented as part of adverse event reporting and service delivery.

There are policies on human resource management. Practising certificates are current for all staff that required them. Staff records have the required information, including staff education records. Staff report access to in-service and external training. An orientation programme is in place and completed.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. Care staff reported there are adequate staff available.

Residents' information is complete and maintained in a secure manner.

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 medium or high risk and/or unattained and of low risk.
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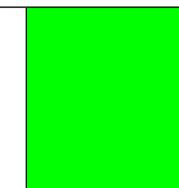
Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Short term care plans are developed when acute conditions are identified and resident's response to treatment is documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported that the activities are enjoyable and meaningful to them.

A medicine management system is implemented. Staff have the required medication competencies. Medications are monitored and reviewed as required.

The individual foods, fluids and nutritional needs of the residents are met. Resident files evidenced that 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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The building complies with legislation and has a current building warrant of fitness. A preventative maintenance programme includes equipment calibration and electrical checks. The environment is appropriate to the needs of the residents.

Each resident's room has natural light, heating and ventilation. There are sufficient numbers of showers in each of the wings. Residents' rooms allow for care to be easily provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. A call bell system allows residents to access help when needed and residents stated that they are responded to in a timely manner.

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. Enablers are utilised as the least restrictive option that allows residents to maintain independence, comfort and safety. There are 17 residents using restraints and one resident is using an enabler. Risk management plans are in place to prevent restraint-related injuries. Staff training on restraints and enablers is conducted annually. Interviewed staff demonstrated adequate 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.
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Infection prevention and control policies and procedures include a comprehensive infection control programme. The infection control programme is reviewed annually. The type of surveillance is appropriate to the size and complexity of the service. Action plans are developed to reduce the infection rates in the service. All staff receive education regarding infection prevention and control.

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	47	0	2	1	0	0
Criteria	0	97	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is part of the staff orientation and ongoing education programme. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents. All residents and families reported that they have high praise for the manner in which the staff interact with them and no concerns requiring breaches of rights were expressed.</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.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The files sampled have signed advance directive forms for resuscitation and antimicrobial usage at end of life.</p> <p>Residents and family/whānau (where appropriate) are included in care decisions.</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 families are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The residents and family are invited to the resident's meetings. Staff demonstrated knowledge of residents' rights and advocacy services.</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 have access to visitors of their choice. There are no restrictions to visiting hours. A number resident's access community support independently, with family or as part of the activities programme. Family members interviewed reported that they are encouraged and welcomed to visit the service at the times of their choice.</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>Complaints information is provided to residents and families as part of the admission process with at least annual updates for residents/families with visits from the advocate. There are complaints forms available throughout the service. The residents and families reported that they feel free to make a complaint if they need to. The residents and families report that issues are addressed almost immediately if they have any concerns.</p> <p>The complaints register contains the complaints, dates and actions taken. There are no outstanding complaints. The complaints sampled reflected timeframes within right 10 of the Code.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and families are provided with information on the Code on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families either individually or as part of the resident's meetings. There is a local visit by the Nationwide Health and Disability Advocacy Service at least once a year. The advocate is available to provide the residents, families and the service advice and support as required.</p> <p>All residents and families reported no concerns requiring breaches of rights were expressed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>All rooms are single occupancy to maintain the residents' personal visual and auditory privacy. If personal discussions and GP examinations are required, these are conducted in the residents own</p>

<p>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>room. Residents who have greater mobility access the GP in the community. Doors were observed to be closed during the delivery of personal care.</p> <p>Residents' interviews and files sampled evidenced that individual values and beliefs are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff demonstrated knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.</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 cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to Tikanga best practice and the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. The in-service education programme includes cultural safety, with cultural safety questionnaires sighted in the staff files sampled. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. Kaumātua and kaiawhina are available to visit the service for individual support of residents or group education for staff and residents.</p> <p>There are residents who currently identify as Maori. The facility manager reported there were no known barriers to Maori accessing the services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process. 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 individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for staff to enable the facility to meet the cultural/spiritual needs of the resident. A number of staff are from culturally and linguistically diverse backgrounds. The service has specific awareness days to recognise the diversity of the residents and staff.</p> <p>Residents reported that their individual cultural needs, values and beliefs are met. Staff confirmed the need to respect the individual cultural, values and beliefs of residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	FA	<p>The employment job description, employment handbook and the Code of Rights define residents' rights relating to discrimination. Staff stated they would report any inappropriate behaviour to the registered nurse (RN). The staff contracts and files record that professional boundaries are included</p>

<p>sexual, financial, or other exploitation.</p>		<p>in contracts and the RNs have attended the required Nursing Council of NZ Code of Conduct training. There was no evidence of any behaviour that required reporting. Residents and families indicated no concerns regarding discrimination.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The planned yearly education programme includes sessions that ensure an environment of good practice. Staff and management have access to online best practice articles and resources to support their ongoing knowledge. Staff are encouraged to access external education and learning opportunities. The service has access and support from visiting specialist nurses, palliative services and mental health teams. Residents' and relatives' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided</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>All residents can effectively communicate in English. Interpreting services can be contacted through the DHB. There is access to Te Reo interpreters through the local Kaumātua.</p> <p>Open disclosure is documented and is noted on incident forms. 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 residents and families report that communication is open and honest.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisations mission, values, philosophy and beliefs are clearly documented in the strategic plan. The strategic plan is a five-year plan, with the progress towards meeting goals and targets reviewed by the board monthly. The organisation has a person centred approach to service delivery.</p> <p>The service is operated by a community charitable trust, and governed by a board of trustees. The service is also part of a wider community trust board, made up of other community trust aged care services across the Waikato district.</p> <p>The day to day management of the services is conducted by a full time manager, who is a registered nurse. The manager provides a monthly report to the board on progress towards meeting organisational goals.</p> <p>The facility manager has managed the service for approximately 10 years. The manager has attended over eight hours' education in the past 12 months related to aged care management, maintaining clinical skills and knowledge. The manager is currently studying master levels management qualifications. The manager maintains ongoing professional knowledge and downloads updates from the Ministry of Health related to the aged care industry.</p>

		<p>Services are planned to meet the needs the residents at the different levels of care, abilities and specific care/rehabilitation needs. Since the last audit the service has renovated one wing of the rest home (in February 2016) and one other room (August 2016) to be suitable for dual purpose occupancy (either rest home or hospital level of care). These rooms are fitted with hospital level of care beds and ceiling hoists. The wing currently has an accessible wet shower room that is suited for disability access, residents on shower chars or bath trolley.</p> <p>This reconfiguration has increased the dual purpose rooms from eight to 17 and reduced the rest home specific rooms from 34 to 25. This makes 25 rest home and 25 dual purpose beds. At the time of audit there were 26 residents receiving rest home level of care, 17 residents receiving hospital level of care and one younger person (under 65 years of age) receiving hospital level of care. The one younger person is receiving age appropriate services and supports.</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>During planned absences of the manager there is a contracted manager who takes over the management of the service. This person is an experienced health service manager. Clinical management is then undertaken by the clinical nurse leader. The manager reports confidence in this team to manage the service during a 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>	PA Low	<p>There are documented quality and risk management plans. The risk management plan was last updated and reviewed by the organisation in September 2015, with the quality plan currently under review and awaiting final approval from the board. The plans outline the organisational goals and objectives for all aspects of service delivery. The strategic plan includes risk analysis and strengths, weaknesses, opportunities and threats analysis. This records organisational risks, actions implemented and monitoring requirements to reduce/minimise the occurrence or impact of the risk.</p> <p>Staff meetings provide a forum for discussing quality and risk issues, as confirmed in the review of meeting minutes and interviews with staff, though there is limited evidence of the evaluation of the quality data (refer to 1.2.3.6). There is also two monthly health and safety meetings (which also includes infection prevention and control) for specific risk and hazards within the service. Staff demonstrated knowledge of the quality and risk management system. There is a designated quality and risk management coordinator.</p> <p>The required policies and procedures are documented. Policies are reviewed in a two-year cycle, or sooner if there are any best practice or legislative changes. The manager and quality coordinator</p>

		<p>review the policies to ensure they are reflective of current practice and legislation. The health and safety policy has been reviewed recently to include changes in legislation. The policies meet the requirements of the standards and are updated based on legislation and best practice. Policies are version controlled. Staff can only access to the most recent version and obsolete documents are archived. There is a system in place to enable the retrieval of documents as needed. Archiving and destruction of records is conducted in line with legislation.</p> <p>The internal auditing system (including safety inspection and satisfaction surveys) is used to monitor the quality and risk management system. The internal audit schedule covers all aspects of service delivery. In the event a shortfall is identified, corrective action/quality improvement plans are commenced. Corrective action plans sighted record the area for improvement, the improvement plan, who is responsible, time frames for implementation and measurable improvement indicators to review if actions implemented have been effective. Feedback from the improvements are communicated with staff at the staff meetings.</p> <p>There is collation of quality data, though limited documented evidence of analysis (refer to 1.2.3.6). Quality data is benchmarked with the other aged care services within the wider community trust group.</p> <p>The service also has a hazard register that identifies the hazards in the facility and delivery of services. This includes risk minimisation strategies to address the risks associated with service provision. The internal auditing system, hazards checklists and inspections are implemented to monitor ongoing compliance.</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>Adverse events are documented on an incident/accident or behavioural incident forms. The adverse events are followed up by the manager. Forms are well annotated with follow-up actions. All serious incidents/accidents are reported to the registered nurse on duty. Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.</p> <p>There is a monthly collection and graphing of the incidents that have occurred. The results are externally benchmarked, with actions implemented to make improvements reviewed at the health and safety meetings. The monthly report also goes to the board.</p> <p>The manager is aware of the essential notification requirements and these are documented in policy. The manager advised that there have been notifications of significant events (e.g. fractured neck of femur). The manager reported a long term stage four pressure injury at the time of audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>All staff and contractors who require a practicing certificate have these verified annually. Current practicing certificates were sighted for all staff who require them.</p> <p>There are policies and procedures on human resource management. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted.</p> <p>An orientation process covers all essential components of the services provided. There is also specific orientation training and competencies for the different roles. Staff members interviewed found the information provided to be informative and supportive. Staff annual performance appraisals were sighted.</p> <p>There is an education plan for the next two years with several sessions confirmed with speakers. The quality coordinator manages the in-service education programme. The 2016 programme was reviewed and evidenced that education is provided in house, online and by staff visiting external facilities. Individual records of education are maintained for each staff member and were sampled. All relevant staff have medication competencies and first aid qualifications. The clinical nurse leader has an interRAI assessment programme competency. Staff reported that they have access to education and enjoyed the programme, with a number of the professional staff accessing post graduate education.</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>There is a documented allocation of staff to meet the needs of the residents at different levels of care. If there is an increase in the level of need (e.g. palliative or acute condition) staffing is increased. Care staff reported that there were adequate staff available and that they were able to complete the work allocated to them. The rosters sampled evidenced that staff are replaced during sick leave.</p> <p>In addition to the care staff, there are sufficient numbers activities, cooking, cleaning, laundry, administration and maintenance staff to meet the needs of the residents and ongoing running of the service. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided. There is at least one RN on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely</p>	<p>FA</p>	<p>Personal information is entered in all residents` records sampled. There are electronic and paper based resident record management systems. Records sampled evidenced entries being documented which include the signature and staff member's designation. Progress notes are entered each shift. All individual records are integrated and evidence multi-disciplinary input.</p>

<p>identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Resident information is not displayed in public view.</p> <p>The current residents paper based records are stored in the nurses` stations which have locked access. There is an onsite archive storage room and storage shed. A system is in place for accessing archived records if and when required. A resident register is maintained by the administrator for easy retrieval and destruction that meets legislative requirements.</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>	<p>FA</p>	<p>Entry to service policies and procedures provide guidelines when a resident is admitted to the facility. There is evidence that admission agreements are signed by the resident or by their families. Residents receive an information pack outlining the services provided by the facility. The manager or clinical team leader (CTL) screen all potential residents prior to entry and records all admission enquiries. Interviewed residents confirmed that they received information prior to admission and had the opportunity to discuss the admission agreement with the manager or CTL. The admission form in use aligns with the requirements of the aged residential contract.</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>	<p>FA</p>	<p>A standard transfer notification form and process from the DHB is utilised when residents are required to be transferred to and from the public hospital. The CTL reported that a transfer aged care envelope is utilised which includes relevant documents to ensure continuity of care. Relatives are involved in all exit or discharges to and from the service. This was confirmed in interviews with family members.</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>	<p>PA Moderate</p>	<p>Medication policies and procedures are documented to meet legislation and regulations.</p> <p>Medicines are stored appropriately, however an improvement is required in relation to monitoring and recording the medicine fridge temperature. There were no expired or unwanted medications and a system is in place for returning expired or unwanted medications. Medication reconciliation is conducted by the RNs when a resident is discharged back to the service.</p> <p>An electronic system medication management system is implemented. This has replaced paper-based medication records. There is photo identification for each resident, allergies/reactions are identified and indications for both regular and "as required" medications are documented.</p> <p>There is evidence that medication records are reviewed at least every three months. RNs conduct weekly and six-monthly stocktakes of the controlled drugs. An improvement is required in relation to the controlled drug register. Standing orders are utilised and processes are in place to ensure safe</p>

		<p>use of medications listed in the standing orders. This is reviewed annually by the GP.</p> <p>The staff administering the lunch time medications complied with the medicine administration policies and procedures. Current medication competencies were evident in staff records sampled. There were no residents self-medicating at the time of the audit. Self-medication policy and procedures is sighted.</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>	PA Low	<p>Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. A system is in place for receiving and utilising supplies. All meals are prepared onsite. Staff who work in the kitchen have food handling certificates. Kitchen staff were observed using safe food handling practices when preparing and serving meals. A kitchen cleaning schedule is in place.</p> <p>Cooked meals are plated from the kitchen to one of the main dining areas and meals for the other dining area are transported in an insulated trolley. Improvement is required with regard to monitoring food temperatures</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. Additional and modified foods are provided. Menus are reviewed by the dietitian annually. The meals are well-presented and residents reported that they are satisfied with the food service and provided with an alternative meal on request.</p> <p>A nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least annually or when needed. All residents are weighed monthly and a care plan is in place for residents with weight changes. These include the required interventions and the provision of food supplements and fortified foods as required.</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>	FA	<p>There is a policy on declining entry to service. The manager reported that there are processes in place when a potential resident is declined. The manager records the declined resident in a notebook and the reason for decline as well as actions taken. Anyone person declined entry is referred back to the referring agency for appropriate level of care placement and advice. The manager also reported that the DHB needs assessors provide the service with a completed level of care assessments to ensure the suitability of the resident prior to viewing the facility.</p>
<p>Standard 1.3.4: Assessment</p>	FA	<p>Registered nurses (RNs) admit residents using standardised risk assessment tools during admission. Assessments are reviewed at least every six months or when there is a change in the</p>

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		resident's condition. Residents are assessed using the interRAI assessment tool within the required time frame. Trends are generated after completing the interRAI assessments and these are the focus of care planning as evidenced in the resident's files sampled.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long term care plans are resident-focused and personalised. There is evidence that the service promotes continuity of care and documented goals are specific and measurable. The RNs develop and implement the long term care plans. Short term care plans are developed when acute conditions are identified. Residents and families reported that they were involved in the development of the long term care plans. Staff are informed regarding changes in the care plans through daily hand overs and staff meetings.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Long and short term care plans are developed by the RNs. The interRAI assessment trends are addressed in the sampled resident's files. Documented interventions in the long and short term care plans are detailed to address the desired goals/outcomes. The effectiveness of the interventions in place are evaluated by the RNs. Wound assessment, monitoring and wound management plans are in place. The service has access to a wound specialist and district nurse from the DHB. Other monitoring forms are in use as applicable, such as weights and observations.
Standard 1.3.7: Planned Activities 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.	FA	Activities provided are appropriate to the needs, age and culture of the residents. The diversional therapist (DT) develops the activity plans using the resident's profile gathered during interviews with the resident and their families. The DT is supported by an activities assistant. Individual activity plans are personalised and are reviewed every three months. Weekly activity plans are posted in all wings and common areas where residents can see what is scheduled for the week. Other residents are also provided with a fortnight activity schedule in their rooms. The under-65 residents were provided with more physical and mental stimulating activities together with the activities provided for the majority of the residents. A participation log is maintained. Residents are referred to the RNs when changes in the resident's involvement in the activities are noted. Interviewed residents and their families reported satisfaction in the activities provided by the service.
Standard 1.3.8: Evaluation	FA	The RNs evaluate the long and short term care plans at least every six months or earlier when a change in health status is noted. Residents are regularly reviewed by the GP, at least every three

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>months or more frequently when required. Activity plans are evaluated by the DT every three months.</p> <p>All changes in the health status are documented and followed up. Evaluations include the residents' degree of achievement towards meeting the desired goals/outcomes. Resident's response to treatment is documented in the short term care plans and resolutions are documented. Changes in both the long and short term care plans are initiated when the desired goals/outcomes are not satisfactory.</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>	<p>FA</p>	<p>There are documented policies and procedures in relation to resident's access to other medical and non-medical services. Referral documentation is maintained in the resident files. The RNs initiate referrals to the wound specialist and other allied services as required. Other specialist referrals are made by the GP. Referrals and options of care are discussed with the resident and their families.</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>There are documented policies and procedures for the management of general waste, recycling, green waste and hazard/clinical substances. General waste is managed through the council collection processes. The disposal of clinical and sharps waste is managed through the local DHB service. Staff demonstrated knowledge on these processes. Training is conducted on waste management and use of personal protective equipment (PPE) as part of orientation and the ongoing education programme. PPE is available in all areas where waste and hazardous substances are managed and observed to be appropriately used.</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 current building warrant of fitness is displayed.</p> <p>There is a preventative maintenance schedule, which records the frequency of the inspections and maintenance regime. Medical equipment records a current calibration certification. Electrical equipment has current test and tagging records. There is a monthly safety inspection as part of the internal audit programme. Hot water checks are conducted monthly, with all readings below the maximum temperature.</p> <p>The physical environment is designed to reduce risk and optimize freedom of mobility. The corridors are wide enough to enable mobility aids and fitted with hand rails to encourage independent mobility.</p>

		<p>There are disability access ramps to the external areas.</p> <p>Residents and family members interviewed report satisfaction with the building layout and facilities.</p> <p>One previous rest home wing has been converted and fitted out as dual purpose rooms. The rooms are suitable to meet the needs of the hospital level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Each wing (shared by approximately eight residents) has at least one shower and two toilets. One wing has rooms with single or shared ensuite access. There are additional toilets located close to the lounge, dining and activities area. The toilets/showers in communal areas have privacy signage. There are additional staff and visitor's toilet facilities. Residents and families reported satisfaction with the toilet/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>	FA	<p>All residents' rooms are large enough for the resident and any mobility equipment and staff. The dual purpose rooms are fitted with ceiling hoists. Staff reported that the rooms are large enough to provide the appropriate level of care.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The dining, lounge and recreational areas are all in separate spaces. Residents report satisfaction with the communal areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	FA	<p>All chemical, cleaning and laundry equipment is stored in secured rooms. Chemicals are labelled with the manufactures/suppliers labelling. Safety data sheets are in the laundry and sluice areas.</p> <p>The linen service is conducted offsite by an externally contracted company. Personal laundry is cleaned onsite by staff. Internal audits are conducted of the cleaning and laundry process to ensure</p>

<p>services appropriate to the setting in which the service is being provided.</p>		<p>effectiveness. Satisfaction surveys are conducted for resident feedback on the effectiveness of the cleaning and laundry. Residents and families reported satisfaction with the cleaning and laundry services.</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>There is an approved evacuation scheme, with six monthly evacuation drills. The reconfiguration of the service did not change the layout of the building and did not require a new evacuation plan.</p> <p>Staff receive training on fire and emergency procedures as part of their orientation and ongoing education. Staff demonstrated knowledge of how to respond in emergency situations. The facility is fitted with fire suppression equipment. Fire equipment testing is conducted, with the annual check last conducted in June to July 2016. There are monthly inspections by a contracted company for compliance with fire, emergency and building warrant of fitness ongoing compliance.</p> <p>The facility is fitted with emergency lighting and power, with an agreement with an external service to access a generator in an emergency. There is access to disaster/civil defence supplies throughout the facility. There is an emergency supply of drinking water and water tanks.</p> <p>Call bells are located in each resident's room, toilet, bathroom and communal areas. There are central panels and a pager system to alert staff when and where the call bell has been activated.</p> <p>Staff conduct a security check at night to lock external doors. The main entry door is locked automatically in the evening, with residents having a swipe key to enable free entry and exit at any time. Residents and families reported they are able to come and go freely from the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All resident areas have at least one external opening window, sliding door for light and ventilation. Each of the resident's rooms and communal areas has central heating.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection</p>	<p>FA</p>	<p>The responsibilities of the infection control coordinator are shared by the manager and CTL.</p> <p>The infection control programme is reviewed annually including ways to reduce the infection rates in the facility. Infection prevention and control is discussed in the staff meetings and daily hand overs. Monthly infection data are also reported to the board of trustees.</p>

<p>to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>Residents and families are encouraged not to visit or accept visitors when unwell. There are hand sanitisers in the common areas and hand basins for the staff, residents and visitors to use.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinators are responsible in facilitating infection control prevention and control activities in the facility.</p> <p>The infection control team is responsible for implementing and evaluating the infection control programme. The service uses the support of the infection control specialist from the DHB as well as the district nurses for infection control prevention and control issues. They also seek the advice from the GP and accredited laboratory. Interviewed staff demonstrated adequate knowledge regarding breaking the chain of infection as well as outbreak management. The GP reported that the RNs contact the medical centre when acute conditions are identified.</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>	<p>FA</p>	<p>There are documented policies and procedures for the prevention and control of infection. Policies align with the current accepted practice and relevant legislative requirements. Policies are readily available for the staff in the nurse's station and procedures are practical, safe and suitable to the type of the service provided. Policies and procedures are reviewed annually by the quality coordinator.</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>	<p>FA</p>	<p>Infection prevention and control education is provided to staff as a component of their ongoing education programme. Infection prevention and control is provided by a suitably qualified person. Infection control education has been provided for the staff as per the education planner. Residents and their families are provided with advice in relation to infection control and prevention activities. Interviewed staff demonstrated adequate knowledge regarding infection prevention and control measures during an outbreak.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The surveillance activities are appropriate to the size and setting of the service. Monthly infection data is collected for all infections based on clinical signs of infections; however, an improvement has been documented in standard 1.2.3 regarding the analysis of this data. Infection data is discussed in the staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint practices are only used when it is clinically indicated and justified. Restraint minimisation policies and procedures are in place, and include definitions, processes and the use of restraints and enablers.</p> <p>There are 17 residents using restraints and one resident using an enabler. Staff interviewed demonstrated adequate knowledge regarding restraints and enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator role is shared by the manager and CTL. The restraint approval process is described in the restraint minimisation policy. The responsibilities of the restraint coordinator and restraint approval committee are clearly defined. The type of restraint to be used is approved by the restraint approval committee prior to commencing the restraint. All restraints in use are reviewed and evaluated every two months to ensure appropriateness and discuss any restraint-related issues.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinators complete a restraint assessment prior commencing the use of any restraint. Assessments are undertaken by one of the restraint coordinators in partnership with the GP, resident and family members. Restraint assessments are based on information in the care plan, resident/family discussions and observations by the staff. Risk management plans are in place for all residents on restraints and enablers to ensure safe use of restraints and enablers. The type of restraint used is included in the long term care plans.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>The service actively promotes the safe use of restraints. The risk management plan ensures resident's safety while using restraint which includes the required frequency of monitoring of the</p>

<p>Services use restraint safely</p>		<p>restraint in use. This was evidenced in the sampled resident's care plans using restraints and there is evidence of recordings on the restraints in use. Residents with falls issues are trialled on low beds before restraints are commenced. Restraint-related injuries are reported and action plans are implemented to address the problem. Policies and procedures are in place and are accessible to the staff to read. Policies around monitoring and observation of restraint use are documented in the policy. The restraint register is current and records the current restraints in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Individual restraint use is evaluated every two months during staff meetings to ensure safe use of the restraint in place. The evaluation form includes the effectiveness of the restraint and the documented risk management plans in the long term care plans. Staff are actively involved in the review of the restraints in use.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The staff monitored the safe use of restraint in relation to the risk management plan in place. The restraint coordinators reviewed the restraint minimisation programme annually and there was only one reported restraint-related injury reported. The restraint coordinators reported that restraint use was reduced secondary to the two-monthly reviews by the health & safety team. Restraint is discussed in the staff meetings as well as daily hand overs. Meeting minutes include a review of the residents on restraint and the required staff education.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is a monthly collation of the number of falls, incidents, accidents, infections and results of internal audits. There is limited documented evidence of the analysis and evaluation of this data. There is some discussion of the data and trends at the health and safety meetings, though no clear process of how the recommendations have been actioned and communicated to other staff members. Quality data is also collated and benchmarked with other aged care services, though again there was limited documented evidence on how this data is analysed and evaluated.	There is limited evidence of the analysis and evaluation of quality data (including infection surveillance).	Provide evidence that there is consistent analysis and evaluation of quality data. 180 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of	PA Moderate	Fourteen medication records were sampled. The time of administration was not documented in five, the date of administration was not documented in two, the name of prescriber was not documented in two and staff were not consistently countersigning the controlled drugs to be administered in six.	The required information in the controlled drugs register has not been consistently	Ensure that staff document all required information in the controlled

detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.		The medication management policy requires the temperature of the medication fridge to be monitored daily, however the temperature was being checked every two weeks.	recorded. The temperature of the medication fridge is not being monitored as frequently as required.	drug register. Monitor the medicine fridge temperature daily, as required. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There are food service policies and procedures in place that complies with the current legislation and guidelines. The cook monitors food temperatures daily, however there are days that food temperatures are not monitored and recorded.	Food temperatures are not consistently monitored and recorded.	Ensure that food temperature is monitored and recorded daily. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.