

# Avatar Management Limited - Maida Vale Retirement Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Avatar Management Limited
<b>Premises audited:</b>	Maida Vale Retirement Village
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 7 March 2017 End date: 9 March 2017
<b>Proposed changes to current services (if any):</b>	The DHB Portfolio Manager has requested clarification of the Hospital – Medical certification in the organisation's scope of services. A reconfiguration of services occurred in August 2016, when the service increased its dual-purpose beds by three (two in Mountain View and one in Woodrow Grove).
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	85

# Executive summary of the audit

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## 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

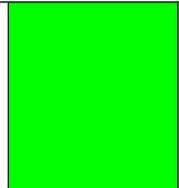
Maida Vale Retirement Village provides rest home and hospital level care for up to ninety-four residents. The service is operated by Avatar Management Services. The operation is overseen and managed by a managing director and a clinical services manager.

The environment and service are appropriate for the provision of additional hospital - medical level care. Residents and families interviewed spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family/whānau, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in a continuous improvement rating in human resources management and training, food and nutrition management and good practice in relation to health and safety systems. There were no areas for improvement identified.

## Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There is no evidence of abuse, neglect or discrimination.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent and act on any advance directives.

Residents who identify as Māori, or other cultures, have their needs met in a manner that respects their individual cultural values and beliefs. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Strategic and quality and risk management plans include the goals, priorities and values of the organisation. Monitoring of the services provided to the board of directors is regular and effective. The managing director is supported by the clinical service manager who is an experienced registered nurse suitably qualified to manage the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and results of benchmarking which leads to improvements. Staff are involved and regular feedback is sought from residents and families. Adverse events are documented with corrective actions and improvements implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training robustly supports safe service delivery, and includes regular individual staff performance review. Staffing levels and skill mix meet the changing needs of residents. Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The general manager and clinical manager oversee the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's record.

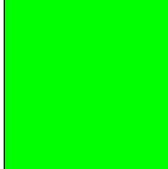
The residents' care plans document the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whanau, are involved in the care planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65. The programme is a strength of the service and meets the interests of the residents.

The service has implemented a web based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications.

The menu plans have been reviewed by a dietitian. Each resident is assessed by the RN and clinical manager on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen has a registered food safety plan, with annual inspections, that complies with current food safety legislation and guidelines.

## 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 facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness for all three buildings. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Eleven enablers and three restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Restraint minimisation is a regular agenda item at the continuous quality improvement (CQI) meetings. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the documentation requirements and restraint and enabler processes.

## 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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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Infection prevention and control policies and procedures are clearly documented and implemented to

minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff. The GP, or other specialised input, is sought as required.

Infection control education is provided by the infection control coordinator or external specialists, who have current knowledge of best practice. The education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are benchmarked, acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	2	99	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	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 in-service and online education programmes. Residents' rights are upheld by staff (eg, 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 Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The relatives reported that residents are treated with respect and dignity. The consumer auditor interviewed four residents under the age of 65.</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</p>

		<p>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 live care. The files reviewed have signed advance care plans that identify residents' wishes and meet legislative requirements</p> <p>Residents and family/whanau (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 family/whanau 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 staff interviewed reported 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 reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged providers and support services for the younger residents.</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 Comments / Compliments / Complaints Policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are available at the reception.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions have been taken, through to an agreed resolution. Each complaint is documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The managing director and clinical services manager are responsible for complaints management and investigation. The complaint is tabled at the next weekly management meeting and reported at the CQI</p>

		<p>meeting each month.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Training has been provided. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<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. Copy of the Code and other information related to rights are in the residents' rooms and displayed throughout the service.</p> <p>Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whānau report that the residents are addressed in a respectful manner that upholds their rights.</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>	FA	<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 resident related information. The service has several younger people and their independence and links with the age appropriate community resources is encouraged. The residents interviewed and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. Staff interviewed report 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 Māori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Māori and the importance of</p>

		<p>whanau.</p> <p>There are residents who currently identify as Māori, with the service meeting the resident's individual needs. The clinical staff reported that there are no known barriers to Māori 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 and ongoing assessment. 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 individual values and beliefs. 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>Residents reported that their individual cultural, values and beliefs are met. Staff confirmed the need to respect the individual culture, values and beliefs of residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family/whanau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The general practitioner (GP) visits the service at least weekly. The GP reports that the service excels at picking up early warning signs of deterioration, to act promptly on health issues before they reach a crisis point. Residents' and relatives' satisfaction surveys evidenced</p>

		<p>overall satisfaction with the quality of the care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included quality projects into pressure injury management, reducing skin tears, the web based medication management system and installation of ceiling hoists.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to communicate effectively in English. Staff able to provide interpretation as and when needed and use family members and volunteers, when appropriate. There are communication strategies in place for residents with cognitive impairment or who have non-verbal means of communication.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and operational plans, which are reviewed annually, outline the values, priorities and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports provided to the managing director and board showed a variety of information to monitor performance is reported. This included performance against a range of clinical indicators, complaints, adverse events, new risks, resident feedback and emerging issues. The board meets monthly to discuss key issues. Minutes sighted were brief, however it was apparent that there were regular meetings and communication between the managing director, senior management team and board most weekdays.</p> <p>The service is managed by the managing director and clinical services</p>

		<p>manager. She holds relevant nursing qualifications and has been in the role for four years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The managing director was not available for the site audit, however the senior management team ably confirmed their knowledge of the sector, regulatory and reporting requirements for the service.</p> <p>The service holds contracts with Taranaki District Health Board and Ministry of Health (MoH) for Aged Residential Care (Hospital and rest home), Young Physically Disabled (YPD), respite care, complex medical conditions, and palliative care. Eighty-five residents were receiving services under these contracts at the time of audit. Hospital level of care is being provided to 41 residents, including five aged under age of 65 years, and rest home care to 44 residents, including one under 65, and four rest home level of care residents in apartments under an occupation right agreement.</p> <p>The DHB Portfolio Manager has requested clarification of the Hospital – Medical certification in the organisation’s scope of services. A reconfiguration of services occurred in August 2016, when the service increased its dual-purpose beds by three (two in Mountain View and one in Woodrow Grove). The service provides a suitable environment and trained staff to meet the needs of group of residents.</p> <p>The service and environment are suitable for the provision of hospital – medical services in an aged care setting.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the managing director is absent, the clinical services manager (CSM) carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by two charge nurses located in Mountain View and Woodrow Grove units. They are experienced in their roles and have been mentored by the CSM to fulfil these extra responsibilities and deal with any clinical issues that may arise. Staff reported the current arrangements meet the needs of the organisation.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of adverse events and complaints, internal audit activities, a regular patient and staff satisfaction survey, monitoring of</p>

<p>continuous quality improvement principles.</p>	<p>outcomes, clinical incidents including infections and restraint use. Maida Vale Retirement Village contributes data to an Australasian benchmarking programme each quarter and receives regular reports which identifies any trends, both positive and negative.</p> <p>Minutes of the monthly continuous quality improvement (CQI) meeting confirmed regular review and analysis of quality indicators and that related information is reported and discussed firstly at the weekly management team meeting. Staff meetings and committee meetings such as the risk management and health and safety meeting, are held regularly. The risk management meeting includes a representative from the Taranaki DHB to support infection prevention and control. Staff reported their involvement in quality and risk management activities through participation in internal audit activities, incident reporting and identification of hazards. Relevant corrective actions are developed and implemented to address any shortfalls through a documented CQI process. Resident, family and staff satisfaction surveys are completed annually and results are reviewed for themes and actions taken where opportunities for improvement are identified. The most recent survey of residents showed a high response rate and general satisfaction with the services provided, including meal services, activities and care. Some suggestions in relation to the increasing the range of activities offered have been implemented.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies sighted were based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Documents are available at the point of use in hard copy. The master copies are retained in electronic format.</p> <p>An organisational risk register details the risks and the strategies used to manage them. Risks are categorised according to their significance. The CSM and village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The home-based support coordinator is the health and safety coordinator. She is familiar with the Health and Safety at Work Act (2015) and has implemented</p>
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		requirements prior to the recent Accident Compensation Corporation (ACC) workplace safety audit, at which the organisation achieved tertiary level compliance for the third time.
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on the organisation's incident form. A sample of incidents forms reviewed showed these were fully completed, investigated and action plans developed and followed-up in a timely manner. Adverse event data is collated each month, analysed and reported to the CQI meeting. Quarterly reporting is undertaken for benchmarking purposes.</p> <p>The CSM and village manager described essential notification reporting requirements, including for pressure injuries. They advised there have been three notifications of these made to the Ministry in the past year. There are currently no police investigations, Worksafe, coroner's inquests, issues based audits or public health notifications in process.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes, based on good employment practice and relevant legislation are consistently implemented. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation has been reviewed for care staff, registered and enrolled nurses and team leaders and includes all necessary components of training relevant to the role. The programme emphasises the organisation's core values and is signed off by a preceptor. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after an eighty-day period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements encompassing fire preparedness, restraint minimisation, manual handling and infection control. Some of the other in-service education is offered as on line courses by a training provider which can be completed in the staff member's own</p>

		<p>time. This has resulted in an increase in completion of a range of modules. Records sighted indicated that a range of topics are offered (eg, abuse and neglect, medication (several), aging processes (several), informed consent and open disclosure). Care staff have either completed or commenced a New Zealand Certificate in Health and Wellbeing (Level 2 and level 3) education programme to meet the requirements of the provider's agreement with the DHB. Three staff have also completed the NZ Certificate in Cleaning (level 2) delivered under the umbrella of the linked training establishment.</p> <p>Maida Vale Retirement Village has offered clinical placements for a NZ Nursing Council approved Competency Assessment programme (CAP) since 2015. The students undertaking clinical placement in the facility are overseen by registered nurse mentors when on site. Resident consent is obtained at the time of entry to the facility for care delivered by staff in training.</p> <p>Records evidence there are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and current completion of all annual performance appraisals. The rate has been improved with the introduction of a new system and reflects continuous improvement.</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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents, with a recent example of increased staffing level to address an increased resident acuity in the hospital. An afterhours on call arrangement is in place with the CSM and charge nurses, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them and felt the senior staff were responsive to workloads. Residents and family interviewed supported this. Observations and review of the current eight-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There is suitable staffing cover for the Occupation Right Agreement apartments accommodating some rest</p>

		<p>home residents noted in the roster. The education programme which introduces potential staff to the aged care environment has been an effective means of providing a larger pool of casual staff for short notice roster gaps. All staff (registered nurses and care staff) are supported to obtain or update their workplace first aid certificates. Records indicate that staff due for updates are booked to attend training with an external provider. New staff undertake first aid training after six months of employment.</p> <p>There is 24 hour/seven days a week (24//7) registered nurse coverage in the hospital areas across the site, including where there is a mix of hospital and rest home residents. Records reviewed indicate that registered nurses and permanent care staff have current first aid certificates to meet contractual requirements.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>The admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on an aged care association agreement. Entry screening processes are documented and communicated to the resident and their family/whānau to ensure the service can meet the needs of the resident. The residents and family/whānau reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments from various funders (eg, DHB, ACC) for either rest home or hospital level of care were sighted in the resident's files sampled.</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>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer to manage the residents safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and EPOA documentation. This was confirmed during residents' files reviewed.</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>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management, using an electronic system, was observed on the days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>The medications are prescribed through the web based system for good electronic prescribing practices, which includes the live update of any changed medications, the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine record. Standing orders are not usually required due to the live updating of the medication record, however, the service does have standing order guidelines that are current and comply with legislation.</p>

		<p>There were two residents in the rest home who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for analysis of any medication errors, with quality projects and internal audits evidencing the reduction in medication errors since the introduction of the web based medication management system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian as being suitable for the residents living in a long-term care facility. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whānau reported being overall satisfied with the meals and fluids provided, including catering for their individual preferences.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The service has a registered food safety plan and has annual external audit on the food management systems. Any non-conformances from the external review have been actioned.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local Needs Assessment and Service Coordination NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. The clinical manager reported that they refer residents to different levels/types of care if they are unable to support the resident (such as psychogeriatric or secure dementia care).</p>

		There is a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The initial assessment, which includes assessment of the resident's health and personal care needs, is completed on the day of admission. Registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments. The interRAI, along with other paper based assessments, information gained from the resident and their family/whānau, referral information, observations and examinations carried out are used as a basis for developing the long-term care plan. The residents and family/whanau expressed satisfaction with the support provided and confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In all files sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the care plan. The care plans are discussed with the clinical team at handover.</p> <p>All health professionals documented in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift changeover. The residents reported satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. One family member comment that they are 'amazed' by the improvement in their relative's physical health and 'overall wellbeing'</p>

		<p>since being admitted to Maida Vale.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The diversional therapist and activities coordinator plan activities to meet the resident's abilities, this includes the needs of the younger people at the service. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and resident's abilities. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys</p> <p>There are activities specific for the younger people living at the service. One younger person and one older resident reported that they felt there could be more outings. The service is aware of this and is considering more ways to support greater community access, especially for residents in wheelchairs. All other residents (including younger people) report that the activities programme is of interest to them.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the built-in evaluation scores when the service reassesses the resident using the interRAI assessment, and records this on their own paper based evaluation record. Care evaluations are conducted for all the residents' needs and recorded how the resident's goals have been met over the past three months.</p> <p>When there are changes in the resident's needs, the service changes the long-term care plan to capture these changes. The long-term care plans identify the need, interventions and evaluation of the interventions. There are also additional short term plans, such as</p>

		wound treatment, falls and falls minimisation plans, which capture any short-term changes. Wound are evaluated at each dressing change and at least weekly by the clinical team. If the issue then becomes a long-term need, these are then recorded and updated on the long-term care plan. Any changes to care plans are reviewed by the clinical team (nurses, caregivers, physiotherapist) at handover.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to radiology, health screening, and medical/surgical specialists. There are several specialists/health providers that also conduct visits to Maida Vale, such as audiologists, podiatrists and dietitians. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There are two designated chemical handlers who have completed the required Chemical Handling Approved Handler Training (HSNO). One staff member has also completed specific pest control training and is certified for a five-year period. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	Current building warrants of fitness (expiry dates: 9 April 2017 and 28 April 2017) are publicly displayed.

<p>environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>The room sizes for the proposed increase in capacity for three more dual purpose beds are confirmed as being appropriate for the provision of both rest home and hospital level services.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b> 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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a majority of rooms in both Mountain View and Woodrow Grove with en suites or shared en suites. Two new large fully accessible bathrooms have recently been completed at the Mountain View facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b> Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Most bedrooms provide single accommodation apart from one large shared room. Where rooms are shared, approval has been sought. There are call bells and privacy curtains for each resident in the shared room. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is adequate room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by care and cleaning staff. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. They have all had training from senior staff and the contracted provider of all the detergents. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plans were approved by the New Zealand Fire Service on the 18 April 2002 for Mountain View, 8 May 2002 for Ocean View and Woodrow Grove on 25 January 2002. A trial evacuation takes place six-monthly and is managed by an approved fire safety officer, an evaluation completed and recommendations followed up immediately. The last one held in November 2016 was sighted with the appropriate follow up completed. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The residents who are receiving rest home care under occupational right agreements in the apartments are also included in all drills and adequate staffing ensures appropriate staff support is provided as required.</p> <p>Adequate supplies for use in the event of a civil defence emergency,</p>

		<p>including food, water, blankets, handheld radios, torches with 10-year lithium battery life were sighted and meet the requirements for the up to 92 residents. Water storage tanks are located around the complex, and there is a generator on site which lasts for up to three hours and access to more generators is available if needed. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Some have doors that open onto outside garden or small patio areas. Heating is provided by way of a central heating system throughout all the buildings both in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities were maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There are designated infection control coordinators for both buildings. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The CQI (quality) committee receives the monthly quality, risk and infection control issues. The review of the infection control programme was conducted in 2017. The programme reviews the effectiveness of the infection control programme, education, surveillance and equipment.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application</p>

		of infection prevention and control principles.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinators implement the infection control programme, with support from all staff. There is also an external contract with the DHB infection control specialist to assist in the development of policies and review of the infection control programme. Infection control matters are discussed at the monthly CQI and staff meeting. If the infection control coordinators require additional advice or support regarding infection prevention and control they can access this through the DHB specialist or the GP.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies and procedures have been developed by the organisation (with input from the external specialist) and reflect current accepted good practice. The service has access to good practice resources from an infection prevention specialist, as noted. The policies are appropriate to the services offered by the facility and are reviewed by Maida Vale staff.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinators and external specialists conduct most of the face to face infection control education. There are online learning modules that are part of the mandatory education programme on infection prevention and control. One of the infection control coordinators interviewed demonstrated current knowledge in infection prevention and control. They have attended ongoing education on current good practice in infection prevention and control.</p> <p>As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene when assisting with toileting.</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</p>	FA	<p>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the</p>

infection control programme.		<p>aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in both the rest home and hospital services.</p> <p>The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed back to the staff at the next staff meeting. The benchmarking reports showed that the service has reduced the total number of infections by 20% in the past year. The infection surveillance records included the review and analysis of the data. With an increase in the number of urinary tract infections, the service implemented actions to reduce the recurrence of spread of the infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator has been in the role or several years and provides support and oversight for enabler and restraint management in the facility. She demonstrated a sound understanding of the organisation's policies, procedures and practice as well as her role and responsibilities.</p> <p>On the day of audit, three residents were using restraints and eleven residents were using enablers across the service, which were the least restrictive and used voluntarily at their request. A similar process of assessment, monitoring and review is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with the charge nurses and care staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of a representative group of staff across the service and the restraint coordinator, are responsible for the approval of the use of restraints, restraint processes and review. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Over</p>

		<p>the past five years, there has been a steady decline in the use of restraints.</p> <p>Evidence of resident involvement, or family/whānau/EPOA involvement, as appropriate in the decision making was on file for each resident. Use of a restraint or an enabler is part of the plan of care and was evident in the interRAI assessments sighted for four residents. One resident who has previously used an enabler, is now unable to give consent for its use. It is recognised that this is now a restraint and a process is underway to ensure appropriate consent is obtained for its use and documented for this resident, who has not previously been assigned an EPOA.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse (RN) undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident, resident's family/whānau/EPOA. The restraint coordinator described the documented processes followed to determine the least restrictive restraint is used to meet the assessed need. There is documented evidence of family/whānau involvement, including family meetings. The general practitioner is involved in the final decision on the safety of the use of the restraint. This is signed off on the restraint consent form. The assessment process identifies the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome is focussed on ensuring the resident's safety and security. Completed assessments were sighted in the records of residents using a restraint and enablers.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and sensor clips).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. The frequency of monitoring reflects the assessed risks for the resident. Records of monitoring include the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed</p>

		<p>at the six-monthly restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours and de-escalation techniques. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when it is in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of four residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at the six-monthly restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and satisfaction that the restraint process meets their family member's needs.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and completion of the required documentation.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the monthly continuous quality improvement meeting and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. An internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the clinical services manager, charge nurse and restraint coordinator confirmed that the use of restraint has been reduced over the past five years from 19 down to three at the time of audit. As from January 2017, the use of restraint is being included as one of the clinical indicators for the</p>

		Australasian benchmarking programme. Analysis and trending data will be available later in 2017.
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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Maida Vale Retirement Village system for completion of performance appraisals has been improved. Previously, there were many that were overdue for completion across the organisation. A new initiative commenced in 2016, which used a different approach and a move away from the time consuming fully paper based system. The reporting lines for many staff meant a heavy workload for the clinical services manager to complete a large number of clinical staff appraisals in a timely manner. The new system has introduced a three-way approach. The person being appraised commences an electronic version of their appraisal, while their peers are randomly selected to provide anonymous feedback (also electronically). This, and education attendance, forms the basis of the one to one appraisal session with the line manager, which is documented, and enables clear goal setting for the following twelve-month period.</p>	<p>The organisation demonstrates innovation and continual improvement in processes for the delivery of education and the management of staff appraisals. The changes and improvements made to the performance appraisal system in the past year has increased completion rates (now at 100%) and provided a more robust and independent view of the staff member's performance.</p>

		The new approach has been readily adopted by staff. At the time of audit, all staff appraisals were complete and current, upcoming annual appraisals scheduled over the next few months, and individual goals for learning established.	
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The service has a six-weekly rotating menu which was approved by a qualified dietician in 2017. Initial assessment of residents includes a dietary assessment and a copy of this is sent to the kitchen. A dietician conducts the initial nutritional assessments, and is involved with any changes with the resident's nutritional needs. One of the residents reviewed in detail had dietitian input for wound care. Four of the files reviewed in Woodrow Grove (three hospital level residents, including one hospital and one resident under 65 years) contained detailed nutritional assessments undertaken by a registered dietician to ensure all needs were met, to promote weight gain and wound healing. The service has conducted a quality project and internal reviews into the nutritional and fluid services, with evidence of improved outcomes in increase of body mass index or weights, reduction in urinary tract infections, and increased wound healing (including non-facility acquired pressure injury healing). The benchmarked results record above average outcomes related to wound care, pressure injury management and infection reduction.</p>	<p>The achievement of the nutritional management systems is rated beyond the expected full attainment. The quality improvement projects and internal reviews sighted have a documented review process which includes analysis and reporting of findings to management, the quality team, staff and residents. The projects and reviews documentation evidences action taken based on findings and improvement to service provision. Resident safety and/or satisfaction have been measured as part of the review process and demonstrate improved outcomes, this has included benchmarking of data and resident/family satisfaction surveys.</p>

End of the report.