

Cantabria Home and Hospital Limited - Cantabria Home and Hospital

Introduction

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

The audit has been conducted by 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:

Legal entity: Cantabria Home and Hospital Limited

Premises audited: Cantabria Home and Hospital

Services audited: Residential disability services - Intellectual; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care

Dates of audit: Start date: 7 June 2017 End date: 8 June 2017

Proposed changes to current services (if any): One wing which is located on the top floor of the main building is no longer being included in this audit. The 22 rooms are used for boarders only and not subject to this audit review. Management have notified the Ministry of Health of this change to bed numbers prior to the audit occurring.

Total beds occupied across all premises included in the audit on the first day of the audit: 159

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
Yellow	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
Red	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

Cantabria Home and Hospital provides rest home and hospital level care for up to 236 residents. The service is operated by private ownership and is one of three facilities owned by the Cantabria Group. Cantabria Home and Hospital is managed by an experienced nurse manager who is one of a team of eight managers on site. Since the previous audit an upstairs wing of 22 beds is no longer used for residents. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board and Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and two general practitioners.

The provider can demonstrate how they meet the requirements of hospital-medical services.

This audit has resulted in a continuous improvement in quality improvement and staff education. There were no identified areas of improvements.

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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The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents, and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori Health Plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

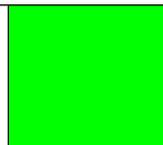
The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

All processes reviewed demonstrate that the provider meet the requirements to offer hospital-medical care.

Residents` information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents` records are maintained in using an integrated hard copy record.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse, general practitioner and nurse practitioner assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

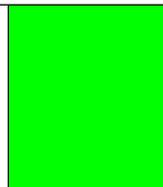
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and medical 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. Five enablers and eight restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the 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.

The infection prevention and control programme, led by an experienced and appropriately trained infection prevention and control coordinator, aims to prevent and manage infections. There are terms of reference for the infection prevention control committee which meets three monthly. Specialist infection prevention and control advice is able to be accessed from the district health board, GP, microbiologist; and/or an infectious disease physician. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	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)
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>Cantabria Home and Hospital has policies and procedures that cover residents' rights. The Code of Health and Disability Services Consumers' Rights (the Code) information is displayed throughout the facility and information brochures are included in resident admission information packs. Staff were observed demonstrating respectful communication, encouraging independence, providing activity options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all new staff employed and in ongoing training, as was verified in the training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies and procedures provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including photographs, outings and sharing of resident information. Additional consent forms were sighted in residents' files, for example, for the annual influenza vaccination and other procedures as applicable.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for resident's unable to consent is defined and documented where relevant in the resident's record as relevant. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>When residents move into the facility, they and their families are provided with a copy of the Code which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available. Residents and family members interviewed were aware of the Advocacy Service, how to access this and the right to have support with this process. Some residents had family who would advocate for them where and when required.</p> <p>Staff interviewed are aware of how to access the Advocacy Service and where to locate the contact details if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents interviewed stated that they were able to freely invite family and friends into the facility to visit them at any time or by arrangement with the nurse manager. Families spoke of being able to come and go as they wished and that they were able to talk to staff if they needed too. Some residents use public transport to get to community activities, such as day services, churches or craft groups. Others are assisted in facility vehicles to get appointments and activities in the community. A designated driver is available to provide this aspect of service delivery.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues 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.</p> <p>The complaints register reviewed showed that 28 complaints/concerns have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where required. The project support advisor and nurse manager are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> <p>A quality improvement has occurred resulting in the updating of complaints forms to make them more user friendly and associated documents have been reworded into simple language to ensure it is easier for family and residents to understand each stage of the process and the written response they receive. All new documents have been approved by the quality group. Feedback related to the newly updated documents is yet to be evaluated.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed were aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service). They received information about the Advocacy Service when they first entered the service as part of the admission process and were able to talk to staff about the service if required. The Code is displayed in English and Maori throughout the facility, together with information on advocacy services and how to make a complaint. Residents' rights and responsibilities are outlined in the admission agreement they or their family/whanau sign when entering the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that support is provided in a manner that has regard for their dignity, privacy, spirituality, sexuality and intimacy. Residents' choices are respected and actioned by staff.</p> <p>Staff were observed maintaining residents' privacy during the audit, including when attending to personal cares and having private conversations. Residents' personal information is held securely and privately, throughout the facility in each service area. All residents have a private room, except for one couple who share a room. Some rooms have ensembles and some have shared bathrooms.</p> <p>Residents are encouraged to maintain their independence by staff who follow clearly documented nursing care plans that state what the resident can and cannot do themselves. Staff assist residents to participate in activities provided within the facility, to attend community activities, to arrange appointments with a visiting physiotherapist and to engage in activities with their family/whanau. Residents confirmed that they were encouraged by staff to do as much for themselves as they could and that assistance was always available for things they found difficult.</p> <p>Records reviewed showed that intimacy and sexuality issues are managed in a manner that ensures the rights of the individual are protected, and intervention only occurs to ensure a balance between the personal rights of the individual and others living and working in the facility.</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,</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers and whanau as appropriate. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledged and respected their individual cultural needs.</p>

values and beliefs.		
<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>Upon entry to the facility, each resident has their religious and value beliefs identified in conjunction with the family/whanau, if appropriate, and recorded in their nursing care plan. Any links with representative or special interest groups that the resident wishes to maintain or develop are also recorded and their needs are accommodated.</p> <p>Staff receive training in assisting residents to meet their value belief needs in a non-judgmental and non-discriminatory manner. Residents are encouraged to feedback any issues or concerns at resident meetings and through the complaints / compliments process.</p> <p>Residents confirmed that they were consulted about any cultural practices, values and beliefs they held and that their personal preferences were accommodated when and wherever possible. Residents' nursing care plans had a specific section relating to cultural and spiritual values and beliefs.</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 interviewed stated that they felt safe in their environment and knew who to go to if they ever felt unsafe. One resident who attends a day service for young disabled people was being supported by staff at the service and facility to deal with a personal issue. A general practitioner also expressed satisfaction with the standard of services provided to the residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. The registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation package and the individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in the staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what constitutes inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The organisation's quality statement confirms its commitment to achieve a working environment based on trust, respect, co-operation and teamwork to encourage innovation, efficiency and productivity to create a safe, satisfying and rewarding environment for employees. Family members interviewed thought that the staff provided a very good standard of care to their family members.</p> <p>The service encourages and promotes best practice through evidence based policies, input from external specialist services and allied health professionals, for example hospice, diabetes nurse specialist, physiotherapist, wound care nurse specialist, DHB dietitians, services for older persons, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed</p>

		<p>the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as gerontology study days / seminars to support contemporary good practice.</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 relative`s health status and general wellbeing. Families were also advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews, sighted in residents` records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Access to interpreter services was facilitated as and when required. Some residents have communication difficulties and staff take time to ensure that in these situations, residents are able to articulate themselves and that staff have understood. Conversations between staff and residents were heard during the audit and indicated that effective communication was taking place. One staff member is able to speak Mandarin and Cantonese and is able to assist with interpreting for one Chinese resident. Communication cards are available for residents for whom English is not their first language.</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 business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of directors (including the owner) showed adequate information to monitor performance is reported including quality data, complaints, monthly occupancy, serious harm, incidents and accidents, staffing hours, financial performance, emerging risks and issues.</p> <p>The service is managed by a nurse manager who holds relevant qualifications including a current annual nursing registration. They have been in the current role for two years. Prior to this role the nurse manager worked for the Cantabria Group at a sister facility as nurse manager for seven years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at quality seminars, related age care education and training sessions, clinical in-service education and district health board meetings. The nurse manager is supported by a team of managers who also ensure appropriate education and knowledge is maintained for the roles they undertake. The management team are supported by clinical team leaders and non-clinical supervisors for all departments.</p>

		<p>The service holds contracts with Lakes District Health Board (LDHB) and the Ministry of Health (MOH). At the time of audit:</p> <ul style="list-style-type: none"> - 130 residents were receiving services under the Age Related Residential Care contract (91 hospital and 40 rest home level), -10 residents None Aged contract with MOH (seven hospital and three rest home level), - four Long Term Chronic contract (one hospital and three rest home level), - four Respite Care (two rest home and two hospital level) and - ten Secure Dementia care rest home level. - one transitional Care contract <p>The following items are met by Cantabria Home and Hospital and demonstrate the services ability to offer hospital-medical services. The provider has policies and procedures aligned with current good practice, human resource processes enable appropriate service provider appointment, the skills mix of staff is aligned with resident needs, staff training is undertaken to a very high standard and along with service delivery other health care provider requests and input are identified. Policy and procedures related to medication management are fully implemented.</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>	<p>FA</p>	<p>When the nurse manager is absent, the senior registered nurses, project support advisor and heads of departments all carry out the required duties under delegated authority. The nurse managers from two sister sites are also available as required. Cantabria Home and Hospital demonstrated progression planning for staff to undertake a variety of roles. During absences of key clinical staff, the clinical management is overseen by other senior clinical registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. The owner is always available by phone if required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</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 incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and falls prevention activities, skin tears, wounds including pressure injuries, and staff education attendance monitoring.</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, quality meetings and staff meetings including allied health. Staff reported their involvement in quality and risk management activities through audit activities, being on special project teams, such as the falls prevention advisory team and undertaking corrective action follow up as required. Relevant corrective actions are developed and implemented to address any shortfalls. This is identified for all areas, both clinical and non-clinical. Examples included the rehousing and updating of emergency and civil defence equipment, appropriate follow up for all incidents and accidents and as part of the response to complaints management, and comments made in the resident and family satisfaction surveys. The service can demonstrate that they use the findings of all quality data to improve services. Quality improvements undertaken are clearly documented to show actions taken, timeframes are met and that outcomes are evaluated. This is performed to a very high standard and has gained a continuous improvement attainment rating.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey showed all follow up was undertaken to improve identified areas of concern. (Refer to comments in 1.2.3.6). Residents and family interviewed confirmed any concerns they have are dealt with promptly.</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 are 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.</p> <p>The nurse manager and health and safety officer (RN) described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. All members of the senior management team interviewed were familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, corrective actions are developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to senior management, the quality group, owner and the board. If there is an increase or trend noted this is discussed in detail at all staff meetings.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been six notifications of significant events made to the Ministry of Health, since the previous audit. (One fracture, one missing resident, one medication error which was a significant adverse event, and three pressure injuries). An infection outbreak was notified to public health in October 2016. There have been no police investigations, coroner's inquests or issues based audits.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. 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. The service has undertaken a review of all current staff files and a quality improvement has occurred to ensure the information is consistently located in the correct part of each file.</p> <p>Staff orientation includes all necessary components relevant to the role. 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 a six week period. If any deficits in staff knowledge is identified, additional education is put in place. All staff annual performance appraisals were up to date.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. This is an area that the service has undertaken a major quality improvement and gained a continued improvement rating. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated 21 registered nurses have completed the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed and resident satisfaction results supported this. Observations and review of six weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All registered staff and activities staff hold current first aid certificates and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</p> <p>There are dedicated, appropriately trained staff who work in the secure dementia care unit.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all resident's information sighted. All necessary demographic, personal, clinical and health information was fully completed in the resident's individual records sampled for review from all areas of</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>service delivery. Clinical notes were current and integrated with general practitioner and allied health service provider records. Records were legible with the name and designation of the person making the entry identifiable. Stamps were used as applicable, dated and signed appropriately.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records 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>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's admission to Lakes District Health Board template which is supported by a facility transfer letter and associated documents to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute hospital showed communication with the hospital, NASC team and family/whanau. Family of the resident reported being kept well informed during the transfer of their relative.</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</p>	FA	<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.</p> <p>A safe system for medicine management (paper based system) was observed on the day 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</p>

<p>and safe practice guidelines.</p>		<p>medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</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>Good prescribing practices noted include the prescriber's signature and 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 chart. Bulk Supply medications are used, are current and usage complies with guidelines.</p> <p>There are three residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen supervisor has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training with updated training due in July 2017.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The 2016 satisfaction survey showed that 75% of residents were</p>

		happy with the general quality of the meals.
<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 NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. 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. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<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>Information is documented using validated nursing assessment tools (such as, pressure injury risk, pain scale, falls risk, skin integrity, nutritional screening and depression scale), as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of 21 trained interRAI assessors on site. Residents and families 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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate</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 two GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very high</p>

services in order to meet their assessed needs and desired outcomes.		standard. 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>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, and five activity assistants.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six monthly care plan review.</p> <p>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. Residents interviewed confirmed they find the programme interesting and interactive and are encouraged to participate. The 2016 relative satisfaction survey found that 68% of residents were happy with the range and variety of recreation activities provided.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, such as music and one to one interaction.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has regular GPs who visit, 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</p>

<p>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>input. Copies of referrals were sighted in residents' files, including to the dietitian, gerontology and mental health services for the older adult. 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>
<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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who deal with chemicals have specific education undertaken related to the safe handling of chemicals. The external company which is contracted to supply and manage all chemicals and cleaning products 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. (Refer comments in criterion 1.2.3.6 related to ground staff access to PPE being made easier as a quality improvement).</p> <p>The health and safety committee oversee audits for waste management and corrective actions are put in place as required.</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>A current building warrant of fitness expiry date 12 October 2017 is publicly displayed.</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 bio medical 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. This includes secure outdoor areas for residents in the secure dementia unit.</p> <p>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>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 111 bedrooms with full ensuite facilities, one bedroom with toilet ensuite only, and 24 bedrooms which have a full ensuite shared between two rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. The bathrooms in older areas of the facility have been upgraded since the previous audit. This is an ongoing refurbishment as shown in the business plan.</p> <p>Five dementia care bedrooms have full ensuite facilities and eight have shared bathroom facilities. These are included in the number shown above.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All but one bedroom which is shared by a husband and wife by choice, are single occupancy. Where rooms are shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs 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>	<p>FA</p>	<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. Each wing has a lounge and dining area with a satellite kitchen for tea and coffee making.</p> <p>There is a large combined lounge and dining area in the secure dementia unit with a satellite kitchen. Activities occur in this area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry area which is well equipped. Family members who request to do personal laundry may do so. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is</p>

<p>with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>managed well and the return of their clothing has improved over the year. (Refer comment in criterion 1.2.3.6 regarding a quality improvement made in this area)</p> <p>There is a designated cleaning team who have received appropriate training in safe chemical handling along with all compulsory education as confirmed in interview of cleaning staff and training records. 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, visual checks of completed laundry and daily cleaning process, and chemical titrates and usage monitored by the chemical provider.</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>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 plan was approved by the New Zealand Fire Service on the 11 October 1995. It has been requested by the New Zealand Fire Service during a trial evacuation that the evacuation scheme should be updated. All paperwork sighted has been sent from Cantabria Home and Hospital and they are awaiting approval. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 30 March 2017. Two issues which arose related to the repainting of fire hydrants and the rezoning of the fire panel in one building (hospital) have been completed. Specific training and competencies are undertaken by all nominated floor wardens. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency have been rehoused in a secure outdoor building (refer comment in criterion 1.2.3.6) and are checked by the health and safety officer monthly. There are adequate supplies of food, water, blankets, mobile phones, torches, batteries and gas BBQ's were sighted and meet the requirements for the 236 residents when the facility is at full occupancy. Water storage tanks with filtration units are located around the complex, and there are two petrol generators on site. Emergency lighting is regularly tested. The emergency plans are reviewed annually (last done in November 2016) to ensure all instructions are in line with DHB stakeholder requirements. The nurse manager or nominated representative attends emergency management meeting with the DHB stakeholders; last meeting minutes sighted dated 28 September 2016. There is a defibrillator on site and all registered nurses have been trained in the correct use of this.</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. Slow response times to call bells were noted as an issue in the 2016 resident satisfaction survey and corrective actions included ongoing staff education and information of actions taken were included in the newsletter sent to all residents and family. Call</p>

		<p>bells were answered promptly during the days of audit.</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. There are CCTV cameras throughout all common areas and these are monitored by the nurse manager and administrator.</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, opening external windows and many rooms, excluding the secure dementia care unit, have doors that open onto outside garden areas. Heating is provided by thermal bore water heated radiators in residents' rooms which can be individually thermostat controlled. Communal areas have heat pumps and radiators. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are 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>The service provider ensures an environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. The programme is signed off annually by management. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the quality manager, infection control coordinator, the DHB infection control nurse specialists, the general practitioners` and others as required. Additional resource material and guidelines are also available to guide staff for the care of residents with a potential communicable disease.</p> <p>A registered nurse is the designated infection prevention control coordinator, whose role and responsibilities are defined in job description. Infection prevention matters, including surveillance results, are reported monthly to the nurse manager, and tabled at the quality/risk committee meeting. A flow chart is evident which identifies reporting and accountability leading to the senior management. The infection control coordinator is also the health and safety coordinator.</p> <p>Signage is available in all areas of the facility and handwashing signage was clearly evident in all service areas. The infection prevention and control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for four years. The infection prevention and control coordinator has undertaken extensive training, updates and infection prevention and control study relevant for this role as verified in training records sighted. The infection prevention and control committee ensures that appropriate information resources are available to staff and that staff are educated in infection control principles and that the infection control programme is maintained.</p> <p>Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The infection prevention and control nurse is a member of an infection prevention and control college. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There was an infection outbreak in October 2016, which was managed efficiently and effectively and all reporting obligations and action was taken.</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 prevention and control policies and procedures reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good handwashing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses and the infection prevention and control coordinator. Content of the training is documented and evaluated to</p>

<p>infection control to all service providers, support staff, and consumers.</p>		<p>ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence occurred, there was evidence that additional staff education has been provided in response. An example of this occurred in October 2016 and staff in all services managed the situation and the outbreak was minimised with timely action and staff awareness of the situation at hand. The infection prevention and control coordinator and staff were commended by the Public Health Service for the reporting, containment and management of the outbreak.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluid intake in the warmer weather.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract, scabies and other infections as they arise. When an infection is identified, a record of this is documented on the infection reporting form. The infection prevention and control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. All data is discussed at the health and safety meetings held three monthly. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. This was verified in the meeting minutes and with staff interviewed. Results are displayed on the staff notice board and staff receive a newsletter. Graphs are produced that identify trends by wing and by service monthly and for the current year, and comparisons by type of infection and volumes against previous years. This is reported to the infection control committee, to the clinical team leaders and nurse manager. Data is benchmarked with two other facilities owned by the service provider. Benchmarking has provided assurance that infection rates in the facility are average for the sector.</p> <p>A summary report for an outbreak October 2016 was reviewed and demonstrated a thorough process for investigation and follow-up. Learnings from the event have been incorporated into practice, with additional staff education implemented through mandatory study days annually for all staff to attend.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, eight residents were using restraints and five residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</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 interviews with staff.
<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 the nurse manager, registered nurse/nurse leader, restraint coordinator, and when appropriate the health and safety coordinator, nurse educator and diversional therapist, are responsible for the approval of the use of restraints and the restraint processes. 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.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</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 RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The RN interviewed/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</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 regular monitoring).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had 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 at each 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>

		Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. Records evidenced 61.4% of staff in 2016 completed training on restraint with 81.8% completing the written component. There was further evidence to show an increase in 2017 of staff meeting the requirements of restraint training with 98.4% completing the training and 97.4% completing the theory.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. 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 documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	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 quality and staff meetings. Minutes of meeting 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. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality improvement data are collected, analysed and evaluated and the results are communicated to staff, residents and family where appropriate. This was shown in all meeting minutes sighted. Results are also communicated to residents and family in the newsletter sent out by the nurse manager as appropriate. Quality data results are sent to the owner each month and discussed at board level as required. All data collected, including audit results, have completed corrective actions which staff confirmed they have been involved in. When an audit result is below par staff, are informed and the audit is repeated within the month to ensure standards have improved. For example, for the cleaning audits where follow up actions were required, each step was clearly documented and resolution dated and reported to senior management.</p> <p>The quality data collected is analysed by the quality group and corrective actions are evaluated by the project support advisor and the nurse manager. All processes are clearly documented. Examples include the results of the resident satisfaction survey which showed that residents' clothing was going missing, and in 2015 it gained a 45% rating. An investigation was undertaken</p>	<p>Having fully attained the criterion the service can, in addition, clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision and resident safety and satisfaction as a result of the review process. Quality improvement data is evaluated, and where necessary, corrective action planning is clearly documented to show what actions need to be undertaken and by whom to enable this process to occur. All quality improvements are evaluated in a manner that is auditable and shows the success or otherwise of actions taken. Reporting</p>

		<p>to find a better way to handle residents' laundry. Discussions were held with laundry staff and the laundry supervisor agreed to 'champion clothing labelling' in order to minimise or prevent residents' clothing going missing. The solution included the facility purchasing a label making machine and a letter went out to all residents and family stating that the facility was offering to label all resident clothing free of charge. This gained a very positive response from existing residents and their families. The laundry supervisor has taken on the responsibility of visiting all residents on admission to gain permission to label their clothing. The results of these actions were measured by the improvement shown in the 2016 resident satisfaction result which gained an 80% satisfaction rating.</p> <p>The falls prevention project has involved staff from all areas of the facility. Comparative data is documented for 2015 and 2016 which shows that whilst the number of falls has not reduced the falls with serious harm injuries has reduced from 3.75% of residents to 0.81%. This project is ongoing and includes raising staff awareness, early falls risk assessments, minimising the risk environmentally and use of appropriate equipment. An addition to the programme for 2017 includes an increase in the exercise programme hours, staff attendance at the DHB falls prevention tool kit for healthcare providers in February 2017, and an increase in falls prevention and management educational sessions for RNs. Following the diversional therapist and activities coordinators attendance at an educational training day related to residents' ability with exercises, an exercise group for residents with Parkinson's has commenced.</p> <p>The health and safety group identified that civil defence equipment was located in various places, a project was then undertaken to find appropriate centralised storage and to ensure all staff were aware of the change of location and how to access the dedicated building. This was linked to staff education, discussed at staff meetings and specific floor warden education was undertaken. All staff interviewed were aware of where to locate civil defence equipment and the role of the floor wardens.</p>	of quality improvements occurs to staff, residents, management and family as appropriate.
<p>Criterion 1.2.7.5 A system to</p>	CI	<p>The service has a comprehensive plan in place to facilitate and record ongoing education for service providers to provide safe and effective services to residents. When the 2016 education in-service training session attendance was evaluated it showed that many of the sessions were very poorly attended</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings,</p>

<p>identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>including the compulsory sessions. A quality improvement plan was developed with input from the quality team which includes the nurse manager. The agreed changes to in-service education presentations were documented and a letter sent to every employee outlining the upcoming changes. The letter reminded staff that as part of their employment contract obligations all compulsory education must be attended. It explained that all staff members training records for the year would become an integral part of the annual performance appraisal. A monthly calendar was produced which is colour coded and anything in 'pink' is a compulsory attendance for all staff. Staff members interviewed had a very good understanding of this. The calendar for 2017 had many additional sessions to allow staff to undertake catch up sessions for education they may have missed for some reason such as annual leave or sick leave. A monthly print off is taken from the annual calendar with any changes and/or additions shown; this is sent to every department.</p> <p>The education for RNs and enrolled nurses was reviewed and a two day programme was established to cover all required core competencies, such as medication management, pressure injury prevention and management, fire safety and evacuation practices, care planning, continence management, infection control, safe swallowing, enteric feeding, challenging behaviour management, pain management, team leadership, moving and handling, health and safety, civil defence and other emergencies. These training days include outside guest speakers. Staff reported they enjoyed the new format.</p> <p>For staff who had very poor education/training attendance a one on one interview with the nurse education officer occurred and a plan was drawn up to show the attendance required to complete outstanding requirements.</p> <p>Every training and education session is evaluated by attendees and recommendations are followed up as required. For example, information related to the writing of progress notes was updated, grounds staff requisition forms for personal protective clothing were relocated for ease of completion, sun screen lotion was made available to staff who work outdoors and earthquake scenarios were undertaken twice due to inappropriate initial staff response. One staff member was unsure about who to report inappropriate behaviour too for fear of jeopardising their role, the follow up actions to manage this are well documented. Staff members who needed support with education such a staff member with a hearing disability had a personalised plan put in place to show how specialised assistance would be given. Some staff members undertook a supported literacy course.</p>	<p>evidence of action taken based on those findings as a result of the review process. Education and training in-service numbers have been compared between the whole of 2016 to May 2017 with significant increases. Staff satisfaction and knowledge has increased with the type and level of training offered which allows them to better perform the role they are employed to do and to ensure resident safety. Staff stated their awareness of all core issues has increased.</p>
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End of the report.