

North Waikato Care of the Aged Trust Board

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	North Waikato Care of the Aged Trust Board
Premises audited:	Kimihia Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 November 2014 End date: 25 November 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	69

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

This certification audit was undertaken to establish compliance with the health and disability services standards and the district health board requirements. Kimihia Home and Hospital provides rest home, dementia and hospital level care with a maximum capacity of 77 beds. A reconfiguration in services was conducted in 2013 which included an increase in the number of hospital beds and a reduction in dementia beds.

Collated evidence gathered indicates that residents are treated with respect and dignity and have their rights upheld in line with consumer rights legislation. An expected level of nursing care and support is being provided. Clinical activities are in line with best practice. The quality and risk management system ensures opportunities for improvement are made. The environment is fit for purpose and maintained in a manner that meets all residents' needs.

Six low risk areas requiring improvement were identified. The organisation is required to maintain sufficient evidence regarding the effectiveness of internal corrective actions, maintain orientation and training records, ensure records of assessments are inclusive of all resident needs, fully document care plan evaluations and complete an overview of the restraint programme.

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.

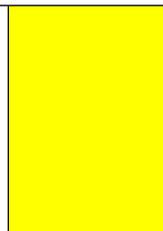
Procedures, interviews with residents, family and staff, together with observations confirmed that residents' rights were understood and met in everyday practice. Communication channels are clearly defined and interviews and observation confirmed communication is effective. Sufficient information on rights and services was provided.

Residents were free from discrimination, exploitation and abuse and neglect. The residents' cultural and spiritual needs were respected and the Maori health plan demonstrated a commitment to the principles of the Treaty of Waitangi. Informed consent requirements were defined and resident and staff interviews confirmed choice was given and informed consent facilitated. Links with the community was supported and facilitated. The principles of open disclosure were followed.

Residents confirmed an understanding of their right to make a complaint or raise a concern. Any complaints or concerns were followed up and remedied in a timely and appropriate manner.

Organisational management

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



Some standards applicable to this service partially attained and of low risk.

The organisation is governed by a board of trustees. The strategic direction and goals of the service are documented and have been reviewed. Day to day operations are the responsibility of facility manager, with support from a senior management team. All members of the management team are suitably qualified.

The required policies, procedures and work instructions were documented and available to those who use them. The integrity of documents was maintained. Policies and procedures reflected current good practice.

Quality and risk management systems were defined, monitored and maintained. All areas of service delivery were assessed for effectiveness and efficiency. Quality related data was analysed and collated to ensure improvements can be made when required. This included adverse events. Internal monitoring was conducted; however an improvement is required regarding records of completed corrective actions

Human resource processes ensured that a sufficient number of trained and competent staff are available at all times. There was a defined process for orientation and training and the extent of training provided was comprehensive. Two improvements, however, are required. This included maintaining full records.

Resident information was held securely and met all requirements for health records management.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service has policies and processes related to entry into the service. Services are provided by suitably qualified and trained staff to meet the needs of residents. The service has provided a number of examples where the care and interventions that have been implemented have improved the residents condition and independence. The care provided is achieving positive outcome for the

residents, though there are improvements required to ensure the assessments and evaluations are documented in sufficient detail to accurately reflect the residents specific needs.

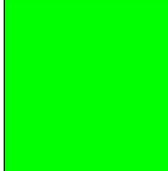
A team approach to care is provided to ensure the continuity of services. Referrals to other health and disability services is planned and co-ordinated as required, based on the individual needs of the resident.

The service has a planned activities programme to meet the recreational needs of the residents living in the rest home, hospital and dementia units. There is a planned programme in the dementia unit with a focus on residents with impaired cognitive function. Residents are encouraged to maintain links with family and the community.

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

Residents' nutritional requirements are met by the service. Residents' likes, dislikes and special diets are catered for, with food available 24 hours a day.

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 is purpose build and divided into separate service areas. Bed numbers were reconfigured in 2013 and this was confirmed as appropriately meeting resident needs. The building, facilities, furnishings and equipment are well maintained and suitable. Applicable building regulations and requirements are met. Well-furnished lounges, dining and family areas are accessible to all residents. The facility has plenty of natural light and was maintained at a comfortable temperature. A variety of bedrooms and units are provided. Each area is sufficiently sized to allow for personal possessions and to accommodate the residents' needs.

Cleaning and laundry services meet infection control requirements and are of an adequate standard. Collection, storage and disposal of waste is in accord with infection control principles. Staff complied with safe waste and hazardous substances processes.

Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. There are adequate numbers of staff trained in first aid and emergency situations on duty at all times. The organisation has appropriate stores and equipment in the event of a civil defence emergency.

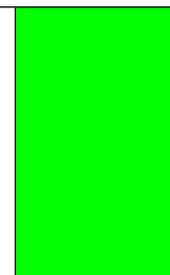
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The restraints and enablers are used for safety and comfort, with assisting to reduce falls being a deciding factor in the use of restraint devices. When enablers are used, these are voluntary and the least restrictive option for the resident. If the resident is not able to consent, then the approval process is followed, which includes gaining consent from the family/whanau. Appropriate assessment, monitoring, evaluations and reviews are documented for the individual residents. A review of all restraint use within the service is required to determine the extent of restraint and identify any trends and the service's progress in reducing restraints.

Infection prevention and control

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



Standards applicable to this service fully attained.

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. The service's infection prevention and control policies and procedures reflect current accepted good practice. Relevant education is provided for staff and when appropriate, the residents. There is a monthly surveillance programme, where infections are collated, analysed and trends compared with previous data. Where trends indicating an increase in infections are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

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	45	0	5	0	0	0
Criteria	0	95	0	6	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>Clinical and non-clinical staff interviewed all demonstrated knowledge and understanding of resident rights, obligations and how to incorporate them as part of their everyday practice. Staff were seen addressing residents with respect, knocking on doors and asking to enter rooms prior to entering and providing residents with choices. Staff interviewed also clearly understood consumer rights and are aware of consumer rights legislation. Training in the Code of Health and Disability Services Consumers` Rights (the Code) has been provided in the last year.</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>The service had sufficient documentation on informed consent and advance directives which identified resident, family, enduring power of attorney and GP involvement. This included the residents` resuscitation wishes. Resident records sampled confirmed that consents and advance directives met requirements and were valid. This included those in the dementia unit.</p> <p>Residents interviewed confirmed that choices were offered and consent</p>

		was obtained for day to day activities.
<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>Policies and procedures required that residents were informed of their right to access independent advocates. This was clearly identified in the resident agreement and signed resident agreements were sighted. Contact numbers for advocacy services were displayed and residents interviewed confirmed that they understood these rights and their entitlement to have the support person of their choice. This was also confirmed in interview with the family member.</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>Visitors could visit residents at the time of their choice. This was confirmed in interviews with residents and family. Access to the community was supported and there was sufficient evidence that those, who were able, continued to access the services of their choice.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service had appropriate systems in place to manage complaints. Policies and procedures on complaints management met the requirements of the Code. The facility manager reported that there had been no external complaints to the Health and Disability Commissioner or the District Health Board since the last audit.</p> <p>Residents and families interviewed confirmed that they had been advised on entry to the facility how to raise concerns or complaints. The complaints procedure was also included in the resident agreement. Minutes of resident meetings confirmed that residents' felt comfortable reporting any concerns.</p> <p>Four internal complaints had been received and investigated for the year to date. The related complaint records were sampled and confirmed that these had been investigated in a timely manner, to the satisfaction of the complainant. A log of complaints, including a six monthly analysis was completed by the facility manager and reported to the board.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Policies were in place to guide staff actions and ensure residents` rights were discussed and available. The Code was clearly displayed throughout the facility. Residents and family members interviewed confirmed they were provided with information on the Code on admission. Information on the Code was also included in the resident agreement. The Code was available in both English and Maori. The Nationwide Health and Disability Advocacy Service poster and pamphlets are displayed.</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>Policies on privacy stated that the organisation respected the privacy of all residents. This was confirmed in interview with residents and family and was observed during the audit. The general practitioner (GP) interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice. There was an abuse and neglect policy available to staff and staff interviewed understood how to report such incidences if suspected or observed. The facility manager reported that any allegations of neglect, as a result of service delivery, were taken seriously and immediately followed up. This was evident in one record sampled.</p> <p>Resident`s personal areas were individualised and privacy was not compromised in shared rooms. Resident`s own property was recorded on admission and a copy was filed in the individual records. There was a system in place for the management of resident funds and reconciliation records were sampled.</p> <p>The residents` preferred name was ascertained on admission and documented and used by staff when addressing residents or family/whanau members. Individual values and wishes were considered. This was confirmed in interviews with residents and family and evident in resident records sampled. There was a chapel in the facility which provided multi-denominational services. It was reported that this was well used by residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>The community has a large Maori community and the service promoted equal access to services for Maori residents. The Maori health plan</p>

<p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>recognised the importance of recognising Maori beliefs and values. The plan was developed by the clinical administration manager (who is Maori) and the facility Kaumatua. The plan included a commitment to the Treaty of Waitangi, reducing barriers to access, advocacy, training and death and dying.</p> <p>On the day of the audit there were 10 residents who identified as Maori. It was reported in interview with the facility manager and clinical administration manager that the number of Maori residents was increasing. Maori staff were employed across all services and 48% of staff identified as Maori. The service also had access to a local Kaumatua, and links with a marae based provider who regularly visited the service providing cultural support and entertainment.</p> <p>The clinical administration manager was developing a cultural assessment based on the Te Whare Tapa Wha model. Two Maori residents interviewed confirmed that their cultural needs were recognised and supported by staff, however the identification of assessed cultural needs was not consistent in all resident records sampled and an improvement has been documented in standard # 1.3.4.2 which refers to the assessment process.</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>	<p>FA</p>	<p>Residents interviewed confirmed that their values and beliefs were actively recognised and well supported by staff. This was confirmed during the audit through observations of interactions between staff and residents. One family member interviewed, with a family member in the dementia unit, reported that staff worked hard at providing care and support which reflected the resident's individual needs, values and beliefs, however the identification of specific values and beliefs was not consistent in all resident records sampled and an improvement has been documented in standard # 1.3.4.2 which refers to the assessment process.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	<p>FA</p>	<p>A current policy on discrimination was sighted. This included guidelines for staff regarding the prevention, identification and management of discrimination, harassment and exploitation. The facility manger</p>

<p>sexual, financial, or other exploitation.</p>		<p>reported that sexuality was managed in a manner that ensured the rights of the individual were protected and intervention occurred to ensure a balance between personal rights of the individual and others living and working in the facility. There were rooms within the facility which could accommodate couples if required.</p> <p>Staff had attended training regarding sexuality for the older person, professional boundaries and code of conduct. Situations which constituted misconduct were included in staff employment agreements.</p> <p>Records of adverse events sampled confirmed that there had been no reported allegations of discrimination or exploitation. This was also confirmed in interview with residents and family. All residents interviewed reported that they felt safe at all times.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Good practice was evident. The service had an experienced clinical team and regular access to the district health board gerontology nurse specialist, wound care specialist and diabetes specialist. A number of staff had also trained in palliative care. The gerontology nurse specialist provided monthly reviews of residents care. The GP interviewed voiced no concerns regarding the competence of staff.</p> <p>The facility manager reported that management endeavours to lead by example. The service supported new graduate nurses and all nurses maintained their nursing port folios. External study and attendance at relevant conferences was supported. Clinical staff meeting minutes sampled confirmed discussions regarding specialist interests for the nurses. Topics included wound care, diabetes, falls prevention, delirium and dementia and palliative care.</p> <p>The service had also forged links within the local sector. This included the formation of a community trust (a collaboration of eight aged care providers) who were working together to establish best practice in the industry and a voice in the sector. The certificate of incorporation was sighted. The board member interviewed confirmed that this initiative was supported by the trustees.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There was evidence that the service adheres to the practice of open disclosure. The facility manager reported that management were open about adverse events which impacted on the residents. This was evident in observations during the audit, adverse event reports and interview with residents and family.</p> <p>Access to interpreter services was available through local interpreter and multicultural services. At the time of the audit there were no residents who did not speak English. Resident meeting minutes sampled confirmed that the service participated in open communication with residents.</p> <p>The residential agreement contained clear descriptions of the services to be provided for both subsidised and non-subsidised resident. This met district health board requirements. Resident agreements were sighted.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation is governed by a board of trustees. Two board members interviewed confirmed there were sufficient processes regarding board membership, frequency of board meetings, strategic direction and monthly board reports. The strategic direction for the organisation was documented and had been approved by the board.</p> <p>There were four managers in the management team. The full time facility manager is a registered nurse with a current practicing certificate. The facility manager had the authority and responsibility for organisational performance including the day to day running of business, financial matters, quality and risk systems and human resources. The facility manager's position description and curriculum vitae confirmed that the facility manager held had the relevant clinical and management qualifications. The facility manager's nursing portfolio provided evidence of on-going training and education. The board conducts an annual performance appraisal for the facility manager. The 2014 performance appraisal was sighted.</p> <p>The facility manager was supported by a clinical nurse manager, clinical administrations manager, household manager and accounts manager. Both clinical managers were registered nurses.</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>The organisational chart accurately reflected reporting lines throughout the organisation. The clinical administration manager performed the role of the facility manager during a temporary absence. The facility manager reported that the clinical manager had successfully performed this role on several occasions. The clinical manager's position description included deputising for the facility manager if required. All members of the senior management team provided on call services.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Policies and procedures were sufficiently documented and identified quality outcomes for key components of service delivery. Policies sampled reflected the aged related contract requirements and best practice. Policy reviews were conducted as required and updates were made by those who used them. There was a system in place which ensured that the current version of all policies, procedures and work instructions were available to staff. Documents sampled during the audit were controlled and had been approved by the facility manager. All obsolete documents were identified as such, removed from circulation and a copy was maintained. Staff interviewed confirmed they were alerted to changes in policies.</p> <p>There was a documented quality and risk management plan which reflected the strategic direction of the organisation. A range of quality activities were implemented and improvement data was analysed to identify trends and themes. Board reports and staff meeting minutes sampled confirmed that quality data, and initiatives, were communicated as required. Staff interviewed reported that summaries of quality data was useful information when planning improvements in service delivery.</p> <p>Compliance with requirements was measured through the implementation of internal audits. Audits were scheduled at regular intervals and covered the scope of the quality system. Audits were sampled and confirmed they have been conducted as scheduled, however evidence that remedial actions had been successful was not consistently documented and an improvement was required.</p>

		<p>Risk management activities and related management plans were documented. Risks had been identified and were being sufficiently monitored by the facility manager and the board. This was confirmed in interviews with both. Risk management activities included the identification of clinical risk, financial and business risk, emergency plans and disaster plans and staff related risks. Health and safety systems were well implemented and the organisation was working towards the workplace safety management programme (supported by the accident compensation corporation).</p> <p>There were sufficiently documented processes regarding financial management. Accounting services were completed by the accounts manager and audited annually as required. The required insurances were sighted.</p>
<p>Standard 1.2.4: Adverse Event Reporting 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>Incident and accident prevention, management and reporting policies/procedures were in place. Incident records sampled confirmed that all reported incidents were taken seriously and treated as opportunities for improvement. Emergency actions were implemented in the event of clinically related incidents and the required clinical observations documented.</p> <p>The facility manager collated all adverse events. This allowed for trend analysis. Results of trends were displayed for staff and reported to the board. Where required, the organisation had changed practice, or implemented initiatives in order to reduce the number of incidents, for example, falls reduction programmes. The organisation also completed a level of benchmarking with other similar providers in the Waikato area.</p> <p>The facility manager demonstrated an awareness regarding essential notifications. Communication with family members was evident and the general practitioner (GP) was notified in a timely manner. This was confirmed in both family and GP interviews.</p>
<p>Standard 1.2.7: Human Resource Management</p>	PA Low	<p>Policies and procedures in relation to human resource management</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>complied with current good employment practice.</p> <p>Nine staff files were sampled. The sample included a range of staff across all services. The skills and knowledge required for each position was evident in job descriptions. Job descriptions outlined accountability, responsibilities and authority. The required recruitment screening (including police checks and reference checks) and validation of professional qualifications was confirmed.</p> <p>The facility manager reported that all new staff received an orientation to the facility and to their respective role, however evidence of orientation had not been consistently maintained and an improvement was required. Records of completed orientation was sampled and included the essential components of service delivery, including emergency procedures. Staff performance was monitored in an ongoing manner and performance appraisals were conducted.</p> <p>The clinical manager was an approved training assessor and there was a comprehensive programme of on-going education. An in service training calendar was developed annually to ensure that staff attended all mandatory training topics, however records of training did not reflect same and an improvement was required. All staff working in the dementia unit had the required dementia related qualifications and staff involved in medication management had their competency.</p> <p>Staff interviewed reported that the support and training they received provided them with the skills they needed. Care givers confirmed they were well supported by the registered nurses. The nurses reported that they were supported by management to continue with their professional development.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The organisation employed 76 staff in total. This included a combination of care givers, administration support staff, auxiliary staff and 14 registered nurses.</p> <p>The documented rationale for determining service provider levels and skill mix was sighted. This took into consideration all service areas and the layout of the facility. The roster was developed by clinical manager. The clinical manager interviewed described the process for decision</p>

		<p>making. This was determined on residents' needs and skills of staff. The roster was randomly sampled to ensure there was sufficiently trained and skilled staff members in each area at all times. This included staff that have completed the required aged care education (including dementia training), medication competencies and first aid training.</p> <p>There were sufficient numbers of suitably qualified staff to cover the 24 hour period. The clinical manager and clinical administration manager were on site during weekdays and on call. There were two registered nurses on duty to cover the entire facility during the night shift. Team leaders for each shift were also allocated. In the event of staff absence, shifts were covered by changing rostered hours or drawing from a pool of permanent casual staff. Work hours were monitored to ensure they remained in line with employment regulations.</p> <p>There was one complaint and one incident which initially raised concerns for management regarding staffing levels. Full investigation was conducted and confirmed that appropriate staffing levels had been maintained. The associated records were sighted. Residents interviewed reported no concerns regarding staff levels.</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>Resident records were well documented and resident files were tidy and well maintained. The requirements for residents' file were defined. Progress notes were written daily and continuity maintained. All entries included the date, time, name and designation of the writer. Resident records were integrated and included input from allied health providers.</p> <p>A register of current residents was maintained. All past and present records were stored in a secure and safe manner and were not publically accessible or observable. Archived records were stored in a safe manner.</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</p>	<p>FA</p>	<p>The service has an admission/enquiry form that records the pre-admission enquiries. The enquiry folder holds a record of the enquiry. The resident admission agreement is based on the Aged Care Association agreement which is individualised to the service. All six</p>

<p>services has been identified.</p>		<p>residents' records reviewed have signed admission agreements. The entry criteria sighted and the service's website clearly identifies that the service provides secure specialist dementia care. Vacancies are updated daily through Eldernet.</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>Risks are identified prior to planned discharges. A transfer form is used that identifies risks. There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided that covers all aspects of care provision and intervention requirements, including any known risks or concerns. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies, record of a summary of medical notes and a copy of any advance directives also accompany the resident if they are transferred to hospital. The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital.</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>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe system for medicine management is observed on the day of audit (RN and a senior caregiver administering the lunch time medications in the rest home and hospital). Medicines are securely stored. Medicines that require refrigeration are stored in a medication fridge. The sighted temperature recordings are within recommended guidelines.</p> <p>The controlled drugs are stored securely. There is a stocktake and reconciliation of the controlled drugs recorded at the bottom of each page of the controlled drug register.</p> <p>The sighted standing orders comply with current legislation and guidelines. The medicine charts reviewed are reviewed by the GP at last three monthly, with this review recorded on the medicine chart. All prescriptions sighted contain the date, medicine name, dose and time of administration., with each prescription signed by the GP. There is a</p>

		<p>specimen signature register maintained for all staff who administer medicines, as well as being recorded on the medication signing sheet. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident. Seventeen of 18 medicine signing sheets are fully completed for the administration of medicines. One of the medicine signing sheets sighted did have one lunch time medication where it is not recorded if the medications were given. This is not reflective of a systemic issue.</p> <p>There are documented competencies sighted for all the staff responsible for medicine management. The RN and senior caregiver administering medicines at the time of audit demonstrate competency related to medicine management.</p> <p>Where a resident is deemed as competent to self-administer their own medications, this process is implemented as required.</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 menu is reviewed by a dietitian as suitable for older people living in long term care facilities. The service has a weight management programme which monitors unexpected weight loss. Where unintentional weight loss is recorded or the resident has a specific need, the resident is referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. There is food and nutritional snacks available 24 hours a day for the all residents. The family/whanau and residents report they are satisfied with the food and fluid services. Feedback was provided from one family member (whose relative requires pureed meals) that at times these are not the 'most attractive' meals. The family member reports they have discussed this with the manager and cook.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. The kitchen service has an annual external review from the council and is certified as meeting food premises requirements, with this expiring in June 2015.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>Interview with the clinical nurse manager reported that the service does not refuse a referral if the resident has a suitable NASC assessment and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found. The clinical nurse manager reported that entry has not been declined. There is a form available to use if a resident is declined entry, this form records the reason for declining and process for informing the relative/resident and referrer if entry is declined.</p> <p>If the resident's needs exceed the level of care provided (for example psychogeriatric), they are reassessed and an appropriate service is found for the resident; this may also involve the crisis team. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>The service has commenced implementation of the electronic interRAI assessment. The service uses some of the organisational paper based assessment tools to complement the interRAI assessment and has not yet completed the rollout of the interRAI to all residents. Assessments are undertaken by a RN.</p> <p>The residents' files reviewed have initial assessments completed on admission. The residents' files reviewed have assessment information that is obtained from previous community interRAI assessments, caregivers, services and, where applicable, the resident's family or nominated representative. Though there are assessment tools available, these are inconsistently utilised and do not always serve as the basis for what is documented in the care plan.</p> <p>The family/whanau and residents interviewed report they receive excellent care that meets the needs of the resident.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' files reviewed have care plans that describe the residents needs and interventions required (also refer to 1.3.4.2 regarding the level of detail that is documented on the care plan. All 10 residents' files reviewed demonstrate integration, with one clinical file that has input from care, activities, medical and allied health services. The nursing and caregiving staff report they receive adequate information to assist the continuity of care. The handover observed includes updates of all residents.</p> <p>The care plans reviewed of the three residents living in the dementia unit identify the resident's individual diversional and recreational requirements, with documented evidence of how these are managed over a 24 hour period. The caregivers interviewed demonstrate knowledge on the management of challenging behaviours. The staff were observed to manage residents behaviours affectively.</p> <p>The family/whanau, residents and the GP report satisfaction with the quality of care provided at the service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>As observed on the day of audit and with review of the care plans, evidence showed that the support and care provided meets the resident's needs. Care is flexible and individualised and focused on the promotion of quality of life. The interventions are consistent with the residents' assessed needs and desired goals, though the appropriate care is provided refer to 1.3.4.2 regarding the improvement required in the documentation of assessment and care plans. The residents' files evidence consultation and involvement of the family. The residents interviewed report satisfaction with the care and services provided. In the dementia unit, the staff interviewed and observed demonstrate good knowledge and skill in minimising the need for restrictive practices through the management of challenging behaviour and redirection of wandering residents. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs.</p> <p>There is a monthly 'paper round' which involves physiotherapy, clinical and facility managers, diversional therapist and the clinical gerontology</p>

		<p>nurse specialist from the DHB . These reviews are conducted for new admissions and residents who need further consultation to achieve improvements in condition. The reviews look at background, assessment and recommendations with an action plan for identified issues. At the next round the responses to the interventions are reviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The monthly activities are developed based on the resident's needs, interests, skill and strengths. The service has diversional therapists and an actives coordinator that provide activities in the rest home, hospital and dementia units. The programmes in each area are designed for the needs of each of these groups. The activities are modified to suit the individual needs and capabilities of each resident. There are groups and individual activities that focus on sensory activities and reminiscence. The diversional therapist reports they try to engage residents interests and long term memories and is adjusting the activities to the increasing dependencies of the residents at the service. The diversional therapist reports that they gauge the level of interest in activities as they are occurring and have the flexibility to change activities based on the residents' response.</p> <p>The dementia unit provides easy access to outside areas that enable the resident to wander safely. There are tactile objects and plants in the outside areas. The three files reviewed of residents living in the dementia unit have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period.</p> <p>The social goals are updated and evaluated in each resident's file at least six monthly. Where possible residents' independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. Families take their relative to religious services as appropriate as well as church services being conducted in the onsite chapel.</p> <p>The family/whanau and residents report that they or their relative enjoys the range and variety of planned activities.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All the residents' files reviewed have a care plan that is signed as reviewed within the past six months. There are inconsistencies in the level of detail in the evaluations of the care provided.</p> <p>If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Short term care plans are sighted for wound care, pain, infections, changes in mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. The nursing and caregiving staff demonstrate good knowledge of the care required if the resident condition has changed and that this is also identified at handover.</p> <p>The family/whanau and residents report that they can consult with the staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The residents are provided with options if required to access other health and disability services, such as public or private health service. There is one GP who visits the service weekly, although residents are able to maintain their own GP if they wish. The RN or the GP arrange for any referral to specialist medical services when it is necessary. The GP and RN interviewed report that referral services respond promptly to referrals sent. Records of the process are maintained in the residents' files reviewed, which includes referrals and consultations with the oncology, surgical, mental health services, hospice, general medicine, wound and diabetes nurse specialists.</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</p>	<p>FA</p>	<p>Documented procedures for the management of waste and hazardous substances were sighted. Hazardous substances were included on the hazard register. An improvement was required regarding the safe storage of oxygen cylinders; however this was remedied on the day of the audit.</p>

<p>substances, generated during service delivery.</p>		<p>Emergency procedures were available regarding exposure to hazardous substances. These included exposure to chemicals and body fluids. Cleaning chemicals were observed to be kept secure and sufficient protective equipment was observed throughout the facility. There had been one reported incident regarding hazardous substances since the last audit. Records sighted confirmed that it was well managed by the facility manager and staff received sufficient support and extra training to avoid any reoccurrence.</p> <p>Staff interviewed confirmed they had received sufficient training on the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building and facilities are well maintained and suitable for the care and support of residents requiring rest home, hospital and secure care. The facility is divided into five separate areas surrounding an internal court yard. Reconfiguration in the number of dementia beds and hospital beds had been made since the last audit. The reconfiguration was approved by the Ministry of Health and was as appropriate during the audit.</p> <p>The facility provides a range of different outdoor and indoor settings. Grounds included evenly surfaced pathways and external seating. Ramps were safe. There was adequate parking for both staff and visitors. There were low stimulus areas and secure gardens for residents with dementia.</p> <p>There are sufficient separate lounge and dining spaces in all areas. Corridors and doorways are wide enough to accommodate equipment and mobility aids. Equipment was observed to be well maintained, calibrated and appropriate to the needs of residents. Sufficient equipment including hoists, chairs, scales and hospital beds were sighted in all areas. Environmental hazards were identified and monitored. Electrical appliances were tested.</p> <p>Maintenance services are provided by a contractor. Maintenance records and requests sighted confirmed ongoing maintenance activities. Additional records sampled included boiler and generator checks and electrical compliance certificates.</p>

		<p>Applicable building regulations and requirements are met. The current building warrant fitness (and related records) were sighted.</p> <p>Residents interviewed reported no concerns regarding the facility and grounds. The 2014 survey results confirmed that residents felt the facility was kept well maintained.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Sufficient numbers of toilets and bathrooms was observed. These included a range of shared facilities and private ensuites. Communal facilities were located throughout the facility and within close proximity to resident's rooms, dining areas and lounges. All facilities were well maintained, in line with infection control requirements. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities. Bathroom facilities can accommodate equipment if required. Hot water was maintained at a consistently safe temperature.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are a variety of room types. This includes units, single bedrooms and shared rooms. Shared rooms in the hospital area accommodated up to four residents. Privacy curtains divided the room and there was sufficient space around each bed for equipment and visitors.</p> <p>In October 2013 the number of dementia beds was reduced by six and the number of hospital beds increased by seven. The facility manager reported that these changes were made in response to the community needs. These changes were observed during the audit and confirmed residents were placed in appropriate and safe areas.</p> <p>Residents and family members interviewed voiced no concerns regarding personal space/bed areas. Bedrooms were decorated with personal items. This included bedrooms in the dementia suite. All bedrooms have at least one external window.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>All areas had adequate, well-furnished lounges and dining areas. Areas were well utilised and sufficiently sized. Dining, lounge and activity</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>areas are separated. Low stimulus areas were available. Residents and family members interviewed voiced no concerns regarding the communal and dining areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed on site by trained laundry staff. The laundry had well defined processes for the management of clean and dirty linen with clearly defined clean and dirty areas. Industrial washing and drying machines were used and chemicals were provided through a closed chemical circuit system. Laundry staff interviewed confirmed attendance at chemical and infection control training.</p> <p>Designated cleaning staff used well stocked cleaning trolleys. All cleaning products were labelled and the cleaning trolleys were safely stored when not in use. Cleaning and laundry hazards were documented and material data safety sheet were displayed. There was adequate personal protective equipment sighted throughout the facility. Cleaning and laundry staff interviewed confirmed they had access to documented cleaning and laundry guidelines.</p> <p>Satisfaction with cleaning and laundry activities was monitored through surveys and resident meetings. Records sampled confirmed general satisfaction. This was also confirmed in resident and family interviews.</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>Appropriate processes are in place to maintain the safety and security of residents over the 24 hours and during an emergency. Working call bells are throughout the facility (including the dementia suite) and there is a security code on entry to the dementia unit.</p> <p>The fire service had approved the current evacuation plan and records of biannual fire evacuations were sighted. Fire systems and emergency evacuation equipment is checked as required. A sprinkle system is in place and evacuation procedures were sighted throughout. The building is separated by fire doors. There is a designated fire warden on each duty. Signage in each resident's room identified the level of support required during mobilisation. This could be used as a quick reference during an evacuation.</p>

		<p>Disaster plans are documented for a range of emergencies and outbreak management and pandemic planning was documented in line with the District Health Board guidelines. Adequate civil defence supplies are available and included the required equipment and stores. There was adequate food and water supplied in the event of an emergency. The generator provided emergency power.</p> <p>Staff interviewed confirmed they received training in the management of emergencies. There was also an adequate number of staff on each duty, each shift, with current first aid training.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility had plenty of natural light throughout. All rooms have at least one good sized window and the temperature was maintained. Heating was provided by use of radiators. There were no concerns voiced by residents, or family regarding the temperature of the facility. A safe smoking area was provided, away from the building.</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 has a documented infection control programme which was reviewed within the last 12 months. This review shows the service is meeting their objectives of the infection control programme.</p> <p>The infection control co-ordinator is the clinical administration manager. The infection control position description has clear guidelines for the accountability and responsibility in the infection control manual. The infection control coordinator is clear on their role and responsibilities related to infection prevention and control matters. There is a monthly infection control committee meeting, which has representatives from the clinical and non-clinical aspects of service delivery. Infection control is a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health departments. Residents with infections are reported to staff at handover, have short term care plans and documentation in the progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at</p>

		<p>entrances. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, though the infection control coordinator reports that this can be difficult at times with residents living in the dementia unit. A monthly newsletter that goes to residents and family includes infection prevention issues, such as cough etiquette and hand washing. The infection control coordinator accesses information published from the DHB for infections that are present in the community.</p> <p>Staff demonstrated good infection prevention and control techniques and awareness of standard precautions, such as hand washing and use of personal protective equipment (PPE).</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 clinical administration manager (RN) has the role of infection prevention and control co-ordinator. The infection control committee includes staff from the clinical and non-clinical aspects of the service. External specialist advice on infection prevention and control issues is available, if and when required, from the DHB infection control nurse specialist, the diagnostic service, GP, pharmacist and the Ministry of Health as required. The infection control co-ordinator undertakes courses in infection prevention and control through the in-service education programme and updates from the DHB. The staff interviewed demonstrated good knowledge of infection prevention and control.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>An infection control policy sets out the expectations the organisation will use to minimise infections. The policies and procedures are reflective of current accepted good practice; this includes resources from the World Health Organisation. It is noted that there are urinary catheters bags soaking in one of the treatment rooms, though these are labelled with the resident's name, there is no record on the sealed containers when the bags were placed in the soaking solution. The policy sighted provides guidelines on the care of the urinary bags. A process for</p>

		<p>recording the time and date is implemented at the time of audit and no further action is required. Staff demonstrated safe and appropriate infection prevention and control practices for all other matters.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is included in orientation and as part of the ongoing in-service education sighted on the provider's calendar. The infection prevention and control education is provided by the infection control co-ordinator and external specialists as required. The service accesses specialist advice through the DHB. The infection control co-ordinator demonstrates knowledge of current accepted good practice in infection prevention and control. There is recorded infection prevention and control education in 2014 which includes standard precautions and hand hygiene, respiratory infections, urinary tract infections, nutrition and hydration. The presentations are referenced to current accepted good practice. Attendance records and a professional portfolio is sighted for the infection control coordinator for ongoing education on infection prevention and control.</p> <p>The staff interviewed demonstrated good knowledge of infection prevention and control. Resident education is conducted as required, such as personal hygiene, cough etiquette and encouragement of fluids. The infection control coordinator reports that if the resident has cognitive impairment, education with the residents can be difficult, though during personal care delivery these residents are prompted with infection control measures, such as hand washing after 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 infection control programme.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of the service as shown in the infection control programme. The external benchmarking consultancy agency's guidelines and definitions for infections are used at the service. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is clearly described in the quality plan and management meetings, to describe actions taken to ensure residents' safety.</p> <p>There is monthly reporting of infections through an externally contracted</p>

		<p>infection control consulting agency. The infection surveillance results are discussed at the staff meetings, with strategies for reducing infections recorded. The surveillance data is compared to previous months and previous year's data. The data records that there was an increase in respiratory infections in September and October 2014 and had remained steady in the winter months. The analysis records this was reflective of the community norms with increased respiratory infection with the change of season and weather at this time of year. The analysis also records that the low level of respiratory infections in the winter months is reflective of preventive measures with vaccination of residents and staff.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service implements policy and procedures to guide staff in the safe use of restraint. This is confirmed in documentation sighted and during staff and management interviews. Policy identifies that the use of enablers is voluntary and is the least restrictive option to meet the needs of the resident to promote independence and safety.</p> <p>At the time of audit there are 15 residents who have restraint or enabler use. The restraints and enablers include bedside rails, chair lap belt and a wandering tracking devise. The restraint register identifies that restraint and enabler use is minimised and used for the safety and comfort of residents.</p> <p>No residents are restrained in the dementia unit. The dementia unit is designed to provide a secure environment for residents to wander freely.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The service currently has 15 residents with the use of bed rails, lap belt or a wander tract devise as a restraint or an enabler. All restraints being used are for the safety and comfort of the resident. The service records these devises as a restraint if the resident is not able to verbalise when they would like these removed. Consent is gained from the EPOA for these residents. The files sampled of residents with restraint use identify that residents have been appropriately assessed and the restraint approval process was followed. The assessment and approval</p>

		<p>process includes determining the need for restraint through appropriate assessment and consultation with the GP and family/whanau. The final approval is gained by the restraint coordinator prior to use. When restraint is approved, there is a consent that is signed by the EPOA, RN and GP. Clinical staff interviewed confirmed they understand the role in restraint use related to ensuring resident safety through monitoring processes. Staff understood the approval process.</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>The restraint coordinator confirmed that restraint is only put in place following appropriate assessment which includes exploring alternatives to restraint or enabler use by identification of triggers, health problems, medications, physical, social or environmental issues. Assessment covers risk and benefits of restraint. Resident safety and comfort is the key determining factor and desired outcome of any restraint used.</p> <p>Restraint assessments are updated at least six monthly as part of the review/evaluation process. Clinical staff interviews identify their understanding of the safe use of restraint and the need to use alternatives wherever possible whilst keeping the residents safe.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator and clinical staff identify that restraint is only applied after consideration is given to all possible alternatives. The approved restraints are the least restrictive methods to keep residents safe (bedside rails, lap belt and a wandering guard device). All restraint goes through the documented approval process. Restraint is monitored according to risk which is shown in the resident's care plan. There is an up to date restraint register in place with clearly auditable information about each restraint in use. The restraint register indicates that restraint is stopped when it is no longer indicated, such as if the residents' condition deteriorates and they are no longer at risk of falls. Detailed restraint monitoring forms record when the restraint is applied, the checks of the resident and when restraint is removed.</p>
<p>Standard 2.2.4: Evaluation</p>	FA	<p>Restraint evaluation is conducted six monthly. Ongoing restraint use</p>

<p>Services evaluate all episodes of restraint.</p>		<p>only occurs following an assessment. This is clearly shown in the restraint register and in the residents' notes and care plan. A six monthly review and internal audit is conducted to ensure the service is meeting the residents' needs and following the process for restraint approval. All restraint review is discussed with the resident and family/whānau as appropriate.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>PA Low</p>	<p>A six monthly quality audit of restraint is conducted. The internal audit covers most of the points at 2.2.5.1, though there is no overall review of the extent of restraint use, any trends and the services progress in reducing restraint.</p> <p>The DHB requirement of D5.4n is partially met.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Completion of internal audits was delegated to a range of staff with final sign off by the facility manager. A large number of internal audits were completed on a regular (and scheduled) basis. Internal audits for 2014 were sampled. The majority of internal audits required no follow up or corrective actions, however three audit records had identified a service shortfall, and although the facility manager reported that these shortfalls had been addressed, this was not evident in the related records.</p>	<p>There was insufficient evidence that corrective action plans had been implemented or effective.</p>	<p>Maintain evidence of corrective actions, and review whether they have been effective.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive</p>	PA Low	<p>An orientation programme was provided. The orientation programme</p>	<p>Records of orientation have not been maintained, or could not be found</p>	<p>Maintain records of orientation.</p>

<p>an orientation/induction programme that covers the essential components of the service provided.</p>		<p>included the essential components of service delivery. Orientation was facilitated by members of the clinical management team. Each new staff member was then inducted to their work area. This was confirmed in both interviews and completed orientation records sampled.</p> <p>Nine staff files were sampled. Three of which belonged to staff who had been employed for a number of years and their orientation records had been archived. The remaining six belonged to staff that had been employed more recently. Orientation records were sighted in two of the six.</p>	<p>during the audit.</p>	<p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>A comprehensive training programme was provided. Records of attendance were maintained for each session. The programme included all mandatory topics. The clinical manager was a training assessor and was able to assess staff against national qualifications including core competencies, dementia, diversional therapy, rehabilitation assessment and cleaning and care taking. The system for ensuring that all staff were receiving the required mandatory training was assessed using the nine staff files sampled. Although there was a good level of attendance, in general, this was not evident in all the staff files sampled. There were some staff that were consistently low attenders, and had not participated in the required (annual)</p>	<p>The system for maintaining training records does not ensure that all staff have completed the required mandatory training topics.</p>	<p>Review the system for recording attendance at training to better ensure all staff are attending the required mandatory training topics.</p> <p>60 days</p>

		training.		
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	<p>The first two residents' files reviewed of residents living in the dementia unit have initial assessments that included identifying behaviours particular to the resident. This is a tick box that identifies if the resident has physical, verbal or wandering behaviours. There are no other assessments sighted in these files that include the triggers, description of the behaviour, contributing factors and solutions/de-escalation techniques. The sample size of files in the dementia unit was increased from two to three to further identify if this is reflected in other files. There is a lack of comprehensive detail of the residents behaviour assessments being conducted or compressive details in the care plans sighted. The progress notes sighted in these three files do describe the residents behaviours, interventions and outcomes of the interventions. It is also observed at the time of audit that the staff had effective strategies in identifying triggers and implementation of de-escalation techniques.</p> <p>In the files reviewed of the residents living in the rest home and hospital, the majority of the files reviewed have care plans that are based on the assessed needs of the resident. In one rest home file it is noted that a resident who has ongoing issues with pain, does not have a documented pain assessment and one file of a resident in the hospital is</p>	<p>Three of the three residents files of residents living in the dementia unit do not evidence a behaviour assessment or have these needs detailed in the care plan. Three other files (two rest home and one hospital) do not have a comprehensive assessment of specific needs, for example cultural needs or pain management.</p>	<p>Provide documented evidence that the assessment process is used to identify resident needs and these needs are described on the care plan.</p> <p>60 days</p>

		identified as embracing their specific culture, though there is no detailed documentation of this being assessed, or interventions documented on the care plan. There are required improvements to ensure that there is consistency in the assessment process, when are resident has a specific or specialised need.		
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	The 10 of 10 care plans reviewed are signed as developed or updated in the past six months. In seven of these care plan evaluations are recorded as 'no change' or similar brief statement. Three of the care plans reviewed (two rest home and one hospital) do record a more detailed evaluation of some aspects of care that reflects the progress of the resident. Across all aspects of the service (rest home, hospital and dementia unit) there is required to be an improvement in the documentation and detail of the evaluation of care.	Seven of the ten care plans reviewed do not have a detailed evaluation of the care that is resident-focused, indicates the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes.	<p>Provide evidence that evaluations are detailed.</p> <p>60 days</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p>	PA Low	There are internal audits conducted six monthly on the restraint process. This restraint monitoring and review does not include an overall review of the services restraint use, if any trends are identified or the services progress in reducing restraint. Individual resident records are reviewed to ensure that restraint use is safe and appropriate for each individual resident, though the services overall	The reviews and internal audits sighted do not include an overall review of the extent of restraint use, any trends and the services progress in reducing restraint.	<p>Conducted a comprehensive review of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The service's progress in reducing</p>

<p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>collated data on restraint use is not sighted. The sighted internal audit for April 2014 includes how the service is meeting their compliance with policies and procedures, staff training and the approval, monitoring, consent and outcomes for individual residents. This internal audit evidences a 100% compliance with process for individual residents. The service is required to conduct an overall review of all restraint use and combined data, not only the individual resident reviews.</p>		<p>restraint</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.