The Napier District Masonic Trust - Taradale Masonic Residential Home & 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 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:	The Napier District Masonic Trust
Premises audited:	Taradale Masonic Residential Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 August 2015 End date: 11 August 2015

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: 65

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

Taradale Masonic Residential Home and Hospital provides rest home and hospital level care for up to 74 residents. The service is managed by a facility manager and a clinical manager. The residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There are no areas identified that require improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information was

brought to the attention of residents (where able), and their families on admission to the facility. Residents and family members confirmed their rights were being met, staff were respectful of their needs and communication was appropriate.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consent is gained as required. Residents and family members are provided with Information prior to giving informed consent and that time is provided if any discussions and explanation are required.

Staff receive regular and ongoing training on resident rights and how these should be implemented on a daily basis. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents. All aspects of service delivery are consistent with upholding and respecting residents' rights.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination or abuse and neglect, with these policies well understood by staff.

The clinical manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The Napier District Masonic Trust is the governing body and is responsible for the service provided at this facility. A strategic plan and quality and risk management systems are fully implemented at Taradale Masonic Residential Home and Hospital and documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the services provided including regular monthly reporting by the managers to the governing body.

The facility is managed by an experienced and suitably qualified manager who has a background in quality. The facility manager is non-clinical and is supported by a clinical manager/registered nurse. The facility manager and clinical manager are supported by a clinical co-ordinator/registered nurse. The clinical manager is responsible for the oversight of the clinical services in the facility.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans were being developed, implemented, monitored and signed off as being completed to address the issue/s that required improvement. Various meetings are held and there was reporting on numbers of various clinical indicators, quality and risk issues and discussion of any trends identified in these meetings. Graphs of clinical indicators were available for staff to view along with meeting minutes.

There are policies and procedures on human resource management, which are implemented at the service. An in-service education programme is provided for staff and study days are held several times during the year. Staff are also required to complete the New Zealand Qualifications Authority Unit Standards.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The clinical manager and clinical co-ordinator are rostered on call after hours.

Resident information is entered into a register in an accurate and timely manner. The privacy of resident information is maintained. The name and designation of staff making entries into residents' clinical records was legible.

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.

Services are being provided by a range of health professionals. Entry to services is made in a timely and equitable manner. Assessments, service plans and evaluations are completed in a comprehensive manner. Clinical and medical needs are identified

and monitored. Service plans are individualised and have been evaluated when clinically indicated. Referral to allied health providers are made as required. Activities are planned to meet the needs of the resident. Sufficient activities and outings were being provided.

An appropriate medication management system is in place. Medications are monitored and reviewed as required. All staff involved in medication administration are assessed as competent.

Nutritional needs are met including residents who had special dietary needs. The menus are appropriate and varied. Food preparation and storage met food safety requirements.

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.

All building and plant comply with legislation with a current building warrant of fitness displayed. A preventative and reactive maintenance programme included equipment and electrical checks.

All residents' bedrooms provide single accommodation and have ensuites toilets and hand basins. Six apartments have full ensuites. Residents' rooms have adequate personal space provided. A number of lounges, dining areas and alcoves are available. External areas are available for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems, including appropriate monitoring systems, are in place to evaluate the effectiveness of these services.

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.

There are adequately documented guidelines on the use of restraints and enablers and behaviours of concern. Restraint use is minimised if able and the use of enablers is voluntary. In the event of restraint use, the required approval, consent, assessment, monitoring and review is conducted. The safety and use of restraint is reviewed regularly to ensure ongoing appropriateness.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance of infections are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	New staff have received education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) as part of their orientation programme. On-going education on the Code is also provided to all staff. Staff demonstrated a good understanding of the requirements of the Code, outlining how these were then incorporated into their everyday practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The informed consent policy guides service providers in relation to informed consent. Evidence was sighted in resident files of formal, documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for the recent 'flu' vaccinations. There was evidence of advance directives signed by the resident. Residents confirmed they were supported to make informed choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff training records. Staff demonstrated their understanding of the advocacy service, with contact details for the service readily available. Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this, although all stated they would feel comfortable about approaching the facility manager should they have any concerns.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain their community interests and networks, and to visit with their families. The service's activities programme includes regular outings in the facility's mobility van and participation in community events. Community groups, different church denominations and entertainers also visit the facility on a regular basis. The service welcomes visitors, and has unrestricted visiting hours. Family members advised they felt very welcome when they come to visit. Residents reported they are supported by staff to access health care services outside of the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The clinical manager is responsible for complaints and there were appropriate systems in place to manage the complaints processes. A complaints register was maintained that included two complaints for 2015 and these were managed appropriately. Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting of complaints to staff. Care staff confirmed this information is reported to them via the quality and staff meetings. The facility manager advised that since the last audit there has been a death of a resident which involved the Police. This case has been referred to the Coroner. The facility manager also advised the Coroner has not yet made a ruling and to date the case remains open. There have been no investigations by the Ministry of Health, Health and Disability Commissioner, DHB and Accident Compensation Corporation (ACC) since the previous audit at this facility.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	During the admission process, new residents and their family were given a copy of the Code and information on the Nationwide Health and Disability Advocacy Service. The facility manager advised this information is discussed with them during the admission process and any questions they may have are answered. Staff are also available to discuss the Code and/or the advocacy service with the individual resident and/or their family at any other time if they require additional information or clarification. Posters of the Code are also displayed at the facility written in both English and Te Reo Maori. Residents and family members were familiar with the Code and the advocacy service. Although none of those interviewed had concerns about any aspect of the services being provided, all stated they would feel comfortable raising issues with any of the staff.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents were addressed by their preferred names. Each resident has a private room, which they are encouraged and supported to personalise. Staff were observed knocking on closed doors before entering, and maintaining the privacy and dignity of residents during personal cares. During interview residents and family members confirmed they were treated respectfully and that the individual needs and preferences of residents was acknowledged and accommodated. The resident and family satisfaction survey collated in August 2015 indicated high resident satisfaction concerning their rights being respected. The resident records included documentation relating to individual cultural, religious and social needs, values and beliefs that had then been incorporated into their individual care plan. The plans also included information on the resident's abilities, and strategies to maintain/maximise their independence. Evidence was sighted that these plans had been developed in conjunction with the resident and/or their family. The service's policy relating to abuse and neglect was understood by staff. Staff gave examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Staff have received education related to abuse and neglect. Staff employment contracts contained information related to expected standards of behaviour, and the disciplinary actions that would ensue should those standards not be met.
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	The service has a 'Maori Health Plan and Cultural Framework' that guides staff relating to meeting the needs of residents who identify as Maori. The facility manager also detailed the networks that have been established locally if additional support is required to support any residents who identify

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.		as Maori. A staff member who identifies as Maori and their partner who speaks Te Reo is also available as an advisor to support residents and staff and takes the lead in ensuring the blessing of buildings
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The individual preferences, values and beliefs of residents were included in the care plans reviewed. These plans included detailed interventions to ensure resident's individual requirements were accommodated. Residents and family members advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members stated that residents were free from any type of discrimination or exploitation. The facility manager advised that the orientation for new staff includes education related to all forms of discrimination and exploitation. Information on this topic is also included in each staff member's employment contract. The staff orientation programme includes information relating to discrimination and there is regular training for all staff on the topic. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has established professional networks to help ensure residents receive services of an appropriate standard, including specialist services at the local District Health Board (DHB). Clinical policies, which are current and reflect best practice, are available to guide staff in care delivery. Registered nurses are also supported to attend external education sessions, such as palliative care.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members was recorded in the progress notes. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning. Resident meetings are held three monthly and minutes were reviewed. The facility manager advised that interpreter services were able to be accessed from the local DHB

		if required. This information is also provided to residents/families as part of the information pack provided as part of the admission process.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Napier District Masonic Trust is responsible for the service provided at Taradale Masonic Residential Home and Hospital (Taradale Masonic). A strategic plan and a quality and risk management plan 2014 -2016 were reviewed and included goals and objectives, mission statement and values. There was evidence of monitoring and review of the goals in the strategic plan. The facility is managed by a facility manager who is non clinical. The facility manager has a master's degree in quality and is also the quality and operations manager which includes oversight for another local facility within the organisation. The facility manager (FM) is responsible for the day-to-day management of the facility. The clinical manager (CM) is an RN with a postgraduate certificate in health science and is responsible for oversight of clinical care. The annual practising certificate for the CM was reviewed and is current. The FM and CM have been their respective roles since 2012. There was evidence in the FM's and CM's files of appropriate ongoing education. The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service. On the first day of this audit there were 65 residents; 38 assessed as rest home level and 27 assessed as hospital level care. Although the six apartments are certified to accommodate residents who have been assessed as requiring rest home level care under the occupational right agreement, the FM reported they have never utilised these rooms for rest home residents. The residents occupying these units are totally independent from the rest of the facility.
Standard 1.2.2: Service Management 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.	FA	There are appropriate systems in place to ensure the day-to-day operation of the service continues should the FM be absent. The facility manager reported the general manager for the trust and the CM fills in for the FM if they are absent and the clinical co-ordinator (CC) fills in for the CM. The FM, CM and CC confirmed their responsibility and authority for these roles. Services provided meet the specific needs of the resident groups within the facility.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established,	FA	A quality and risk management plan was reviewed and is used to guide the quality programme and includes goals and objectives. The resident and family satisfaction survey was collated in August 2015 and results indicated that

documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		residents and families were highly satisfied with the services provided. Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. Review of the quality improvement data provided evidence the data was being collected, collated, and comprehensively analysed to identify trends and corrective actions developed and evaluated. The FM and CM provide and present monthly reports to the trust board. Management, quality/restraint/infection control, health and safety, staff, and RN/EN meetings are held monthly and minutes were reviewed. There was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the staff areas. Observations during the audit confirmed this. A monthly newsletter is produced which keeps residents and families informed with what is happening at Taradale Masonic. Policies and procedures are relevant to the scope and complexity of the service; reflect current accepted good practice, and reference legislative requirements. Policies and procedures are reviewed by senior management and are current. Staff confirmed that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for service delivery. A health and safety manual is available. There is a hazard reporting system available as well as a hazard register.
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.	FA	Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the FM and CM and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. Registered nurses undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. Staff confirmed that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they are completing accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control). The FM stated they have reported essential notifications to external agencies since the previous audit.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. A nurse educator is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided by way of several study days throughout the year and staff are required to attend one of these days. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessment questionnaires are current for medication management and restraint. Three registered nurses have the required interRAI assessments training and competencies. Key interRAI staff are supported by the clinical manager and the clinical coordinator who have the required training and competency. All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were in the staff files. An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation, including competency assessments (as appropriate).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours a day, seven days a week. On call after hours is provided by the CM and CC. The minimum number of care staff on duty is during the night and consists of one RN and three caregivers. Registered nurses, enrolled nurses and staff who drive the van have a current first aid certificate. Residents and family reported staff provide them with adequate care. Care staff reported there were adequate staff available and that they are able to get through their work. Residents and

		families reported there were enough staff on duty to provide adequate care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Resident related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Archived material was also kept securely but was easily retrievable. All components of the residents' records reviewed included the resident's unique identifier. The clinical records reviewed were well organised and integrated, including information such as medical notes, assessment information and reports from other health professionals. Resident progress notes were completed every shift, detailing resident response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes clearly identify the name of the person making the entry.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Information regarding the services offered is publically accessible. There are documented processes for the management of enquiries and entry. The clinical manager maintained a record of all enquiries and provided the local needs assessor with current bed availability. Decisions on acceptance to entry were determined on level of need and bed availability. Admission requirements were conducted within the specified time frames. All residents signed an admission agreement on entry. The agreement clearly identified the services provided (and not provided) as part of the agreement. Additional charges (where applicable) were identified. Residents confirmed that they received sufficient information regarding the services to be provided. Family members reported that the organisation provided the admission process in a timely and supportive manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Nursing staff reported that transfers and exits occurred either between internal services and/or to other external providers. There was sufficient evidence in the resident records that when a resident transferred from one level of care to another (within the facility) that the required re-assessments were updated/conducted. In the event the resident was transferred from, or to another facility, the required documentation was completed. Family members reported they were kept informed of the need to transfer the resident if required.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There were documented policies and procedures for all stages of medicine management. Policies reflected legislative requirements and safe practice guidelines. Standing orders met the requirements of current guidelines. A pre-packed medication system is implemented. All medicines were prescribed by the GP. Medication reconciliation was completed when medication entered the facility. Medications were safely stored in medication trollies in both the rest home and hospital. Bulk supplies of medications were safely stored in the hospital dispensary and were not used for residents residing in the rest home. Routine checks were conducted for expiry dates and medication fridge temperatures were monitored. Controlled drugs were kept securely and checked regularly as required. The pharmacy completed the six monthly stocktake. Non pre-packed medications were labelled and dated when opened. Medications were administered by staff who had been assessed as competent to do so. Competencies for medication management were monitored. Two medication rounds were observed and confirmed that administration was safely managed. Medication charts were sampled from both service areas. Medication records included suitable identification and allergies were recorded. Three monthly GP reviews were evident. Accurate medication administration records were maintained and specimen signatures documented. There was a process for assessing the competency of residents who self-administered their own medications. This process was confirmed. Medication errors were reported using the incident and accident reporting process. The organisation conducted internal audits on the medication management system. Internal audits sampled confirmed that corrective actions were implemented as required.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There was a four week seasonal rotating menu which had been reviewed by a registered dietitian to confirm it was appropriate for the nutritional needs of the older person. Deviations from the menu were recorded. In general, residents were satisfied with the food. The meal service was observed to be well presented and sufficient in quantity. Nutritional assessments were completed on entry. Special dietary needs were identified and the cook confirmed a knowledge of the dietary needs, allergies, likes and dislikes of each resident. These were displayed in the kitchen. Residents' weight is monitored regularly. Where required, additional nutritional support was documented and appropriate interventions implemented. The GP reviews the weight charts during

		medical reviews. Kitchen staff have the required food safety qualifications. Nutrition and safe food management policies defined the requirements for all aspects of food safety. The kitchen and pantry were sighted and observed to be clean, well-stocked and tidy. Labels and dates were on all containers and records of temperature monitoring were maintained.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The clinical manager reported that a declined entry decision was made if the potential resident was not considered suitable or there was no bed availability. It was reported that in this event the manager provided information on alternative providers and the needs assessor was advised. Documented processes provided guidelines on the management of declined entry.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All assessments were completed on interRAI. Outcomes and goals were documented. InterRAI assessments were used to generate the service plans. Additional assessments were documented where clinically indicated. Needs assessments confirmed the appropriate level of care and placement. The general practitioner and physiotherapist confirmed their involvement throughout the assessment process. The residents and family members confirmed that the assessment process on admission was comprehensive and conducted in a sensitive manner.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment information is used to generate the long term service plans. Goals and related interventions (including routine observations) were documented for each identified goal. The service plans reflected the current needs of the resident. Short term care plans were well utilised for any additional support needs. If the short term need became a long term concern, they were added to the long term service plan. Staff confirmed they have full access to the service plans and read them prior to each duty. Physiotherapy plans, social plans and nutritional plans were also documented. Residents and family members confirmed their involvement in the service planning process.
Standard 1.3.6: Service Delivery/Interventions	FA	Interventions were documented for each nursing objective/goal within the service plan. There was also evidence in progress notes that the required interventions were being provided. The GP was confident that prescribed interventions were implemented and any deviations were reported in a

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		timely manner. In addition, regular interventions such as nursing observations and caregiver tasks were documented. These included bowel charts, temperature/pulse and blood pressure charts, behaviour charts and activities of daily living charts. There was a system in place to ensure these interventions were monitored by the registered nurses. Meetings were conducted to assess individual independence for each resident and ensured service plans included the required interventions.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are designated activities staff on site five and a half days per week. Both the rest home and hospital had separate programmes and some activities were joined. The activities plans in the rest home and hospital confirmed that a wide range of appropriate activities were provided. This included both internal activities and regular outings for those able to attend. All residents had a social assessment completed on admission. This was used to generate an individualised activity plan and goals. Attendance at activities was monitored and activity plans were reviewed every six months. Residents confirmed that attendance at activities was voluntary, and that they could choose from the range of activities on offer.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Service plans were required to be formally evaluate residents every six months, and the existing plan be updated as required. Service plans reviews were completed on interRAI and included input from staff and residents/family. Reviews were fully documented and included current status, required changes and achievement towards goals. Clinical meetings were also conducted weekly. These meetings included discussion regarding any resident who had been of concern over the last week. Daily checklists were completed by the caregivers which indicated achievement in activities of daily living. Short term care plans are used when progress is different from expected. Short term plans and interventions sighted included wounds and infections. Wound care plans included the required assessment and monitoring interventions, as did the service plans for the resident with an infection. Wound and infection care plans are evaluated at each dressing change.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	There was a documented process for the management of referrals. A number of referrals to specialist services were included in the sample and confirmed that referrals were made in an appropriate and timely manner. The GP confirmed that processes were in place to ensure that all

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		referrals were followed up accordingly. Residents and family confirmed that they were offered referrals to other health professionals as appropriate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes are in place for the management of waste and hazardous substances including specific labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances. Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled were provided and being used by staff. For example, gloves, aprons, and masks and visors were sighted.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on the 1 November 2015. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place that ensures buildings; plant and equipment are maintained to a high standard. Documentation reviewed, the maintenance person interviewed and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment is current. There are several external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Care staff confirmed they have access to appropriate equipment. Equipment is checked before use and staff are assessed as competent to use any equipment. Residents confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents they are able to move freely around the facility and that the accommodation meets their needs. Since the previous audit, there have been a number of non-resident rooms that were underutilised in the hospital area that have been reconfigured and altered internally to provide a new medication

		room, a new nurse's station, a new cleaner's room, a family room and storage room. The ambulance bay has also had a roof added.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	Bedrooms throughout the facility have a mix of washhand basins, toilets and some with their own and shared ensuites. The six apartments have full ensuites. There are an adequate number of accessible communal showers, toilets and hand basins for residents. Toilets and showers are of an appropriate design. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature. Communal toilets and showers have a system that indicates if it they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All bedrooms provide single accommodation. All rooms were personalised to varying degrees. Bedrooms have large enough to provide personal space for residents, and allow staff and equipment to move around safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Adequate access is provided to the lounges and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in	FA	Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals/poisons. All linen is washed on site and there is a dirty to clean flow provided in the spacious laundry. A laundry person is responsible for the management of laundry. The laundry person and FM described the management of laundry including the transportation, sorting, storage, laundering, and

which the service is being provided.		the return of clean laundry to the residents. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner described the cleaning processes. Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available, and hygiene standards are maintained in storage areas. Residents and families stated they were satisfied with the cleaning and laundry service. This finding was confirmed during review of the satisfaction survey questionnaires.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Documented systems were in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification were available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors were available. A New Zealand Fire Service letter approving the fire evacuation scheme dated 2 October 2013 was sighted. The last trial evacuation was held on 20 March 2015. Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'. Information in relation to emergency and security situations is readily available/displayed for service providers and residents, emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. There is emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones. There is a call bell system in place that is used by the residents or staff members to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach, and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. The six apartments form a wing in the main facility, and the independent residents residing in the apartments have call bells they can activate in an emergency. During normal working hours the educator/RN would respond and after hours the RN or EN on duty. A policy and procedure was

		reviewed specific to these apartments.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Covered areas outside the building are available for both residents and staff who smoke.
Standard 3.1: Infection control management 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.	FA	Taradale Masonic provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme. There is a documented infection control programme. It is the responsibility of the infection control coordinator (ICC) to ensure appropriate resources are available and to deliver the programme. The infection control practices are guided by the infection control manual and assistance from the DHB infection control nurse where needed. It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined, as confirmed in staff interviews. The ICC records monthly infection rate data, as evidenced in files reviewed and infection records, and presents a monthly report to the quality committee. The ICC liaises with the facility manager and the clinical manager over any serious infection related issues. All infection statistics and the results of analysis are available for staff. The ICC meets three monthly at the DHB with other ICCs to discuss infections and for support. The infection control programme was last reviewed on the 28 May 2015. The infection control coordinator reported there has been an outbreak recently in the facility. Interview of the infection control coordinator and staff and review of documentation provided evidence that this was managed appropriately including frequent reports to the local DHB.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to	FA	The infection control co coordinator is responsible for implementing the infection control programme. A position description is included in the infection control (IC) programme. The ICC and observation confirmed there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview confirmed the

implement the infection control programme and meet the needs of the organisation.		ICC attends regular ongoing training. The ICC facilitates the implementation of the infection control programme as evidenced by data collection records, action plans, completed audits and competency assessments, resources on-site to prevent infections and manage outbreaks and training records of infection control training for staff. Any IC concerns are discussed by the IC committee and reported at the monthly quality meeting and staff meetings.
Standard 3.3: Policies and procedures 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.	FA	Policies and procedures for Taradale Masonic are in place and are current. The service also uses a specialist infection control consultancy agency's manual as a resource. These reflect current accepted good practice. Staff were able to describe the requirements of standard precautions and knew where the policies and procedures for staff are kept. Cleaning, laundry and kitchen staff were observed to be compliant with generalised infection control practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff have received orientation and ongoing education in infection control and prevention as confirmed by staff training records and interviews. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits were reviewed including observations of staff washing hands. Resident education occurs in a manner that recognises and meets the residents' and families' communication style. Resident and family confirmed their knowledge of the recent outbreak.
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.	FA	In line with the facility's infection prevention and control policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is determined by the infection control programme. Interview with the ICC and documentation reviewed evidenced all infections are recorded on a monthly resident infection, monitoring and data collection form and include but is not limited to; event site, infection type, culture, treatment type - start date and end date. This data is collated and analysed to identify any significant trends or possible causative factors. Any ongoing actions required are implemented.

		Infection control matters including surveillance are discussed by the infection control committee which meets three monthly. The committee is the infection control coordinator, facility manager, clinical manager and clinical coordinator. Surveillance results are reported at the quality and staff meeting as confirmed in the meeting minutes.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The facility actively worked to reduce the use of restraint. Sensor mats and low beds were provided for residents who were at risk of falling out of bed and additional monitoring was provided for residents who were at risk of falling when mobilising. The current restraint register was sighted and confirmed that all restraints and enablers were from the approved list. Restraints were evident in the continuing care wing, with one enabler being used in the rest home. Bed rails were the most commonly used restraint. The one enabler had been requested by the resident and was voluntary. The restraint assessment approval process confirmed that the least restrictive option was chosen and alternatives to restraint had been explored. All staff received education on the use of restraints, enablers and the management of behaviours of concern. The definition of restraint and enablers was congruent with the relevant standard. All staff demonstrated knowledge in the difference between a restraint and an enabler.
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.	FA	The documented restraint approval process defined clear lines of accountability for restraint use. Approval for restraint included the registered nurse, GP, resident (if able) and family member. There was sufficient evidence that family feedback was acted on and considered. Resident's records confirmed the approval process was fully implemented.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	There is a comprehensive restraint assessment process. This included the history of the resident and any previous restraint/enabler use, the type of restraint, alternatives and any further recommendations, associated risks and desired outcomes. The required assessments were sighted in resident records sampled where a restraint was in use and had been approved.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint register was current. Continuing care residents who have been assessed as requiring bed rails were medically fragile and had limited mobility. The use of bed rails was observed during the audit and sighted as safe. The restraint coordinator reported that there had been no recent incidents or accidents related to restraint use. All bed rails had protective covers and sufficient staff monitoring was in place. The monitoring requirements for each episode of restraint was documented and staff were observed conducting monitoring rounds for those residents who were unable to leave their bed independently. Staff were aware of the safety issues when a restraint was in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Regular reviews are conducted on all restraint use and this was evident in records sampled. Reviews included discussions on alternative options, service plans, least amount of time, and impact on the resident, adequate support, sufficient monitoring and any changes required. Discussions on the number and use of restraints was also included in management meetings and quality committee meetings. The restraint coordinator reported that restraint use was frequently discussed with regard to alternative options. The GP also confirmed involvement in the restraint review process.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The use of restraint was discussed at quality meetings. Meetings minutes confirmed discussions on restraint were occurring. This included a review of all restraint use. An annual review of the restraint programme was also conducted. Minutes confirmed that all restraint use was appropriate. Assessment and monitoring was reported to be appropriate. Restraint use was minimised where able. Policies and procedures were current and staff training was sufficient.

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.

No data to display

End of the report.