Nurse Maude Association - Nurse Maude Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Nurse Maude Association
Premises audited:	Nurse Maude Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 October 2015 End date: 16 May 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: 32

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

Nurse Maude Hospital, which is part of the Nurse Maude Association, is certified to provide geriatric hospital level care for up to 39 residents, however, currently only 36 beds are used, with occupancy on the days of audit at 32.

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

Residents and family members interviewed provided positive feedback on the care provided.

There are four areas identified as requiring improvement relating to: informing residents and family members of their rights; completion of staff training; and documentation on service delivery plans, including changes identified as part of the evaluation process.

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

The Code of Health and Disability Services Consumers Rights (the Code) is on display and staff and managers are familiar with its content. These are being upheld during service delivery.

Throughout the audit, there was evidence that the service providers were respectful to the residents and their family/whanau, their privacy was ensured and the residents' independence is promoted as far as possible.

Although there are not currently any people who identify with their Maori culture in the hospital service, there is a Maori plan, a Maori advisor and a range of resources, including links to a kaumatua, to support any future resident with Maori cultural needs.

Cultural and religious beliefs are respected and there is no evidence of discrimination, abuse or neglect, for which the organisation has a zero tolerance. An on-site research institute provides the hospital with additional information and resources regarding best practice.

Information about advocacy services is available; families are encouraged to be involved at all levels and informed consent processes are in place.

The complaints process meets legislative requirements and complaints reviewed were responded to in a timely and sensitive manner. Complaints are used to make improvements whenever possible.

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.

A strategic plan establishes the direction of Nurse Maude services, including the Nurse Maude Hospital, with each service developing their own service and quality plans. These include values for the organisation and are reviewed yearly as part of the planning cycle. Outcomes are monitored at service, senior management, and clinical governance levels and by the Board of Directors. Both the organisation and the hospital service are managed by suitably qualified and experienced staff.

The quality and risk management system ensures an integrated and planned approach and includes an internal audit programme, patient and family satisfaction surveys, incident and complaints management, and a range of quality improvement projects. Adverse events are documented on accident/incident forms. Discussion with staff and review of reports and meeting minutes show that data is graphed and trended and that when required, corrective action plans are being implemented to address any shortfalls. Policies and procedures are current in readiness for transition to a new electronic system. Risks to the organisation are identified and plans implemented to mitigate these. Progress on this is monitored at the senior management team and board levels.

Policies and procedures on human resources management guide practice and there was evidence in the personnel files reviewed that these are implemented. Staff complete an orientation programme that meets their needs. An in-service education programme is provided for staff, however not all staff have attended mandatory training requirements, and this requires attention.

There is a documented and implemented rationale for determining staffing levels and skill mix in order to provide safe service delivery.

Health records are managed appropriately and compliance monitoring occurs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Entry to the service is occurring according to contractual requirements and organisational policy and procedures, which also state that a waiting list is not maintained. Assistance and advice is provided by the clinical manager when it is necessary to decline entry because of full occupancy.

A clinical manager and experienced registered nurses oversee enrolled nurses and trained caregivers to provide care and support to the residents. Assessment tools, deemed as suitable for this industry, are in use and are used alongside interRAI. The resident and family members are consulted for the establishment of personalised goals. InterRAI is not yet being used for care planning purposes, however the results of all forms of assessment and consultation with family and other professionals are contributing to the identification of care needs, and development of applicable interventions in the service delivery plans. Service delivery plans are used to guide the care and support provided.

Following completion of a personal profile, Te Ora plans are developed for each resident and guide their activities. Comprehensive and flexible monthly activity plans are in place and reflect the personal interests of residents.

A multidisciplinary approach is used for the evaluations and reviews, which are occurring six monthly and as needed. The outcomes are documented in the care plans.

A safe medication management system was observed and implemented. The staff who assist in medicine management are assessed as competent to do so.

The kitchen services are provided by an external contracted catering company, who prepare and cook food at the onsite kitchen. Food and fluids were provided to meet the needs of the residents. The nutritional services take into account the special needs, likes and dislikes of the residents

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.

Nurse Maude has effective waste management policy and processes for all their sites and services including clinical, laundry and kitchen that ensure the safety of staff, contractors, visitors and residents.

Nurse Maude facilities are located over multiple sites and buildings. There is a very good level of signage to meet health and safety requirements. The facilities and equipment are well managed and are maintained through contracted services.

Residents' personal space including toilets and showers are of a good standard. Outdoor areas meet the needs of the residents and visitors.

An onsite contracted laundry service is well run and meets the needs of the organisation.

Overall there are good emergency and security systems that support the wellbeing and safety of staff and residents. Nurse Maude contracts a security service which provides site inspections, and emergency response according to set protocol. There are back up utilities systems in place for power, oxygen and water.

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 documented guidelines on the use of restraints and enablers and behaviours of concern. There is currently one resident using restraints and one resident using an enabler. There are comprehensive processes for approval, consent, assessment, monitoring and review which are being undertaken. Staff are competent in the safe use of restraints and are overseen by a designated restraint coordinator. Monthly and six monthly reports are provided to the Nurse Maude quality and risk committee.

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.

There is a managed environment, which minimises the risk of infection to residents, service providers, and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually. There were adequate human, physical, and information resources to implement the infection control programme and meet the needs of the service. The documented policies and procedures for the prevention and control of infections reflect current accepted good practice and relevant legislative requirements. These policies and procedures are practical, safe, and suitable for hospital level of care.

Surveillance for infection is conducted monthly with agreed objectives, priorities, and methods that have been specified in the infection control programme. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes were acted upon, evaluated, and reported to staff and management 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	46	0	3	1	0	0
Criteria	0	97	0	2	2	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	Service providers demonstrated respect to residents and a consciousness of their safety as per the Code, while assisting and communicating with them. Records in the personal files include details on how cultural and religious needs are being upheld. The nurse manager and staff inform they are educated about consumer rights every one to two years and this is evident in the staff training schedule.
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	FA	A policy on informed consent notes that all residents will be fully informed, includes a definition of informed consent, notes that staff will be educated about informed consent and lists the requirements for informed consent. A completed informed consent form was in all service delivery files reviewed. The form contains a detailed list of topics such as education, the use of photographs and their rights under the Health and Safety legislation that are reportedly covered in discussion prior to the form being signed. Informed consent forms are signed at the time of a resident being admitted. Enduring power of attorney sign these when the resident is unable to do this for themselves. There is not currently any hospital resident with an active advanced directive. There are clear guidelines for palliative/end of life care and one family member confirmed these have been discussed with them.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The clinical manager informed that there has not been a need to request the services of the nationwide advocacy services, but that every effort is made to listen to family members who may be concerned about a residents' welfare no matter how minor. All family members spoken with stated that staff listen to them and that the senior staff are good at ensuring any issue is satisfactorily addressed before it becomes a problem. Volunteers are additional team members and those interviewed said they will speak up for residents at times, or assist if they see staff are busy.
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	Family members and other visitors were observed coming and going from the facility. Interviews with residents and family members confirmed staff comments that visitors are welcome and family members are involved in the admission and review processes for residents. The signatures of family members in residents' files verify they are consulted. There is a team of volunteers that support the delivery of services in the Nurse Maude hospital. They were observed assisting with feeding at lunchtime and playing music and secondary school students sat and talked with some of residents. Volunteers stated they are welcome, support the busy staff and that they feel valued. Residents may go out if they are physically able and reports and documentation about them going to church and family meals for example were provided.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The consumer complaints policy defines the principles and practice around management of complaints for Nurse Maude and meets the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). There are various ways in which patients/families can make a complaint, including through use of a 'suggestions' form which is displayed in the hospital area. Despite this, discussion around this process does not always occur and not all those interviewed knew how to do so. (Refer criterion 1.1.2.3). Staff and managers interviewed understood the complaints management process and examples of sensitive and timely resolution were discussed, including working with the local advocacy service. Complaints are reported to the Senior Management Team, Clinical Governance Group and the Board (via the Quality and Risk Sub-committee) and timeframes for resolution are tracked by the Quality and Risk Coordinator. The complaints register and two complaints reviewed in detail showed a fair, transparent and timely process. There have been no complaints received via the Health and Disability Commissioner to date this year. Examples of improvements made as a result of complaints were provided and discussed.
Standard 1.1.2:	PA Low	Information about the nationwide health and disability advocacy service is on display, as is the Code of Health

Consumer Rights During Service Delivery Consumers are informed of their rights.		and Disability Services Consumers Rights (the Code). A copy of the brochure on the Code is provided on entry to the service and additional information on advocacy services and residents' rights is in the accompanying information pack about Nurse Maude residential services. Residents and relatives interviewed were not aware of the Code and although staff are aware of residents' rights they advise that admission times are busy and talking about them may be missed at times. The need for residents to be better informed of their rights is a required improvement.
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	A privacy and confidentiality policy refers to legislation that relates to privacy and confidentiality and outlines the role of the organisation's privacy officer. Residents have their own rooms and staff were observed to knock before entering bedrooms and bathrooms, including when a bell had been rung. Respect of the residents was evident in all interactions between staff and residents. Individual service delivery plans include ways in which people will be assisted to maintain their independence, despite their increasing frailty, as well as ways in which individual values, beliefs and cultural or ethnic needs will be met. Examples of this occurring were evident, especially for religious and ethnic beliefs and for supporting people to maintain their mobility, to feed themselves and to make their own decisions. A family violence policy provides staff with a framework to identify and manage family violence, abuse and neglect. It notes staff will be educated to observe any signs of abuse or neglect, take any required actions and will be familiar with related legislation. There was no evidence of any signs of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Nurse Maude has a Maori Plan and a Maori advisor. The Maori Plan is responsive to the particular needs of people within the local Maori community. It incorporates the responsibilities of the organisation in relation to the Treaty of Waitangi; is aligned with the strategic plan and business plans and is reviewed annually. A section details the resources available to hospital staff to ensure the needs of Maori people would be adequately met. There are not currently any residents in the hospital who identify as Maori, however, the Maori advisor informed of how this would occur and spoke of her links with the local Kaiāwhina. Reference was made to staff training on the Treaty of Waitangi, the availability of informative resources on tikanga and the need for the staff to consult the person and their whanau to determine any specific requirements. It was explained how staff have access to and are able to consult with appropriate support networks for Maori service users, including Maori chaplaincy, advocates, Taua and Kaumatua.
Standard 1.1.6: Recognition And Respect Of The Individual's	FA	A cultural safety policy describes the organisation's commitment to ensuring all staff, patients, clients, families and whanau feel respected and culturally safe. The intention is that the cultural background and requirements of

Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		all persons will be respected and that all special cultural requirements will be met. Individual values and beliefs are documented in the residents' service delivery plans, as are specific cultural and ethnic needs. Additional information obtained from the residents and/or family members on admission are detailed in a personal profile. Examples of how such needs may be met are included in the service delivery plan. Staff reported on how they meet the needs of a person with specific cultural needs and the family members expressed satisfaction with the manner in which these are met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There was no evidence of any form of exploitation during interviews with residents, family members, volunteers and staff. Nor were there any reports of staff not working within their professional boundaries. Among the staff, there is a diversity of ethnicities and cultures and the clinical manager stated that this helps to ensure residents remain free from discrimination. A harassment policy notes that harassment of any type whether sexual, racial, physical or verbal, is not tolerated by the organisation. It also states that any complaints of harassment from staff or volunteers will be investigated and action taken against offenders where appropriate. Residents spoken with stated staff are all 'fair and good' and relatives said that the residents are 'in good hands'.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are minimal complaints about the services being provided. Overall, service provision is consistent with current accepted good practice and there is evidence of information obtained from projects undertaken by the on-site research institute having an impact on service delivery. Examples of these include the management of hydration, continence and reducing falls, where procedures have been altered according to the research/project findings. Likewise the Te Ora activities programme was trialled prior to its implementation. Continuous improvement is occurring, however further results of evaluation are needed to demonstrate the differences the changes have made before this rating could be awarded.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	An open disclosure policy that references Right 6 of the Code is in place. Residents and family members interviewed said that they are kept well informed. Family members stated that they are informed about anything that happens immediately and that questions are always answered. Staff members and the clinical manager gave examples of open disclosure having occurred following a person falling, a skin tears and a medicine error. There is an interpreter policy that includes details on how to access local interpreter services. Staff are aware of these services. The clinical manager provided examples of how they have managed people whose first language is not English by using family members and even staff at times to assist with interpretation. A new resident of Asian ethnicity has a comprehensive language chart that has been developed in consultation with a

communication.		family member.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A range of planning documents sighted demonstrate that a rigorous process is in place to guide service development across the Nurse Maude services. The strategic plan establishes the overall direction and strategic goals for the organisation. It is agreed by the board and forms the basis on which the performance of the Chief Executive and management team is assessed. Progress against the strategic plan is reviewed by the board and a review of a sample of board meeting minutes over the past year show relevant and appropriate monitoring and reporting. The chair of the board interviewed reports that adequate information is provided to monitor progress and identify an emerging issues and risks. Service level plans, the human resources plan, quality plans and the Maori health plan reviewed were in line with the strategic plan. Values are defined. Planning follows a cyclical process with plans being reviewed on a regular yearly basis. The organisation is managed by a well-qualified and experienced chief executive who is supported by a senior management team (SMT) of 10, including the Director of Nursing and a general manager who oversees the aged care facility hospital. The hospital area is managed by a clinical nurse manager who is skilled and experienced in this role. Authority and accountability is defined through job descriptions and organisational charts and evidence of this was supported through review of relevant personnel files.
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	Members of the Senior Management Team (SMT) interviewed discussed arrangements and reporting lines when the Chief Executive and/or other senior team members are absent. This process is also defined in policy. Any 'direct reports' are notified of any changes.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented,	FA	A culture of quality and safety improvement is evident at Nurse Maude, guided by a planned and structured approach to managing quality and risk. Members of the SMT, the board chair and managers interviewed demonstrated a commitment to quality improvement and safety. The structure to support quality and risk was discussed with the Quality and Risk Coordinator and the Director of Nursing and shows linkages between the various committees, roles and components. The SMT, the Clinical Governance Group and the Quality and Risk

and maintained quality and risk management system that reflects continuous quality improvement principles.		Subcommittee of the Board play key roles in ensuring appropriate monitoring of quality and risk indicators and that the various components of quality (eg, incidents, complaints, audit activities and quality improvement projects) are linked. The Ethical Clinical Committee acts as the organisation's restraint committee, reporting to the Clinical Governance Group. The Quality and Risk Coordinator oversees quality across the organisation supported by senior management roles and service based quality teams, including two recently appointed quality facilitators, working in the service areas to support quality activities. The organisation participates in the Baldridge Business Excellence programme and the EQuIP accreditation programme. Senior managers are also well aware of the work of the Health Quality Safety Commission (HQSC) and relevant components are integrated into the organisation's quality programme. Quality data are gathered through a range of activities with data analysed and graphically displayed and reported to the relevant forums, including staff meeting forums. The quality programme includes various patient and family/whanau satisfaction surveys, with a whānau feedback group now established within the hospital setting. Minutes reviewed demonstrate active participation and feedback on relevant topics. An audit programme covers review of a range of different systems, policies and processes. Where issues are identified corrective actions are developed and examples of this were reviewed and discussed with the Clinical Nurse Manager of the hospital, the Quality and Risk Coordinator and other senior staff. Improvements in the management of policies and procedures, in readiness for the imminent transition to the 'SharePoint' system, have led to all policies and procedures being current at the time of audit, or in the process of review. This is tracked through an administrator role and use of a document control register. Policies are reviewed three yearly or more frequently if required, referenced to relevant legislation and best practice and approved through various committees as appropriate. Easy access to policies for staff remains an issue; this will be addressed through the new SharePoint system. Some clinical policies are accessed through the Lippincott system and the Canterbury District Health Board (eg, infusion policies). Where this occurs there are appropriate systems to do so. Risk management meets the requirements of the Standard, with this process guided by policy. The overall organisation wide risk register and a sample of a service based risks register sighted, show that relevant risks are identified, rated and mitigation action plans developed and reported on. Risks are reviewed at the SMT and the Board Audit and Finance Committee; as confirmed by review of minute meetings. The Board Chairperson interviewed commented on key risks being monitored at board level and was satisfied with reporting processes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded	FA	The current paper based system for reporting and managing incidents will be replaced by a new electronic system in the near future; this is planned for 2016. Although the current system does not support easy analysis of data this system meets minimum requirements. The national severity assessment code (SAC) system is used and the organisation voluntarily reports SAC 1 or SAC 2 events to the HQSC. Root cause analysis (RCA) is carried out for more serious events and any resulting recommendations are implemented by the relevant

by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		service quality team, with oversight by the specific general manager. External advice is sought as part of the RCA process, as was discussed in an example related to a pressure injury. Adverse events are reported internally to the Clinical Governance Group and to the Board. The Quality and Risk Coordinator now maintains a corrective action register to better monitor progress in implementation of corrective actions. Improvements in trends related to pressure areas, medication error rates and falls show that corrective actions to address issues are effective. The Director of Nursing and the Quality and Risk Coordinator interviewed are aware of requirements around statutory and regulatory reporting and examples of this occurring (eg, to the Coroner), were discussed.
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.	PA Low	Human resources policies describe good employment practices that meet the requirements of legislation. Newly appointed staff are police vetted upon employment, referees are checked and job descriptions clearly describe staff responsibilities. Staff complete an orientation/induction programme that includes the essential components of the job. Staff that require professional qualifications have these validated as part of the employment process and annually, as confirmed in documentation sighted, including for the pharmacist and general practitioner who provides services. Twelve personnel files reviewed (including registered nurses, enrolled nurses and care assistants) showed that all requirements had been met, with the exception of those staff employed some years ago when not all the current requirements were necessary. Several volunteers work in the service to support residents. Interview with the Volunteer Coordinator and review of two personnel files show that that employment, orientation, ongoing training and monitoring of performance meets good practice standards. Ongoing education requirements are defined and records are held by the Clinical Nurse Manager, in the hospital area. It was not possible to determine from the records if all mandatory requirements have been completed. Performance appraisals are all current and this was verified by the Service Manager, Clinical Nurse Manager and in the spreadsheet reviewed electronically and the personnel files. Resident and family/whānau members interviewed were very satisfied with the services delivered.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The Hospital Staffing and Rostering Procedure reviewed as part of the audit process is based on the 'Thornton ARC review conducted in 2010' and on the requirements for 36 residents. A benchmarking process has also been undertaken to determine the needs at the Nurse Maude Hospital. The number of registered nurses (RNs), enrolled nurses (ENs) and hospital aides are defined. The Clinical Nurse Manager interviewed discussed the rostering process and the current and previous weeks rosters were reviewed, showing that the required numbers were rostered and any leave (planned or unplanned) was covered with an equivalent staff member. Both the Service Manager and the Clinical Nurse Manager reported that staffing can be increased to respond to unexpected short term demand.

		While feedback from residents and families was positive about the services delivered, including verbal feedback during the audit and satisfaction surveys reviewed, there were some negative comments about timely response to bells and the heavy workload of hospital aide staff. This was discussed on site with managers who indicated that a further review of staffing in this area was planned for early in 2016. There are no clinical indicators (eg, falls, pressure areas) to indicate that safe and appropriate care is not being delivered, with improvements overtime in these indicators.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Currently the health records are predominantly paper based and overseen on site by the service manager. These are held in a lockable cabinet at reception and are locked when not in use. Health records reviewed were current and contained all relevant information pertaining to the resident's care. There is a central electronic database (Client Management System) held in the main office of Nurse Maude that records the consumer's key information (name, address etc) and automatically generates and allocates an unique identifier. The NHI number once known is added to the database and is able to be searched by either identifier. Health record compliance audits are undertaken and monitored through the Quality and Risk committee. The organisation also has an appointed Privacy Officer who also monitors compliance. Staff are trained in health record management including training on privacy and confidentiality. Health record coding relates to contractual requirements and where applicable national guidelines. The implementation of a new Patient Management system (PMS) project named CRISTA is nearing the Go Live date which has been deferred from 2015 until early 2016.
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	An access and entry policy and procedure details criteria for entry to Nurse Maude residential hospital services. This document describes any services, which are the responsibility of the resident to pay for. The clinical manager noted that referrals may be received from a range of sources, including family, GPs, social workers, palliative care clinical nurse specialists and the local hospital. All residents require a needs assessment to be undertaken by a Needs Assessment and Services Coordination (NASC) service prior to admission. Only people assessed as needing hospital level care and support are accepted. A comprehensive information pack is provided to all potential residents and their whanau. The personal files of seven residents reviewed included admission agreements that meet contractual requirements. All admission agreements sighted have been signed and the agreements for those admitted in the last six to nine months have had these signed at the time of admission and clearly show family/whanau involvement.
Standard 1.3.10: Transition, Exit,	FA	There are very few residents who transition or discharge from the Nurse Maude hospital and the clinical manager could not recall any such event in recent times. However, residents may transfer for additional

Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		treatment to Christchurch hospital, for example, if they become injured or are unwell. There is a protocol for this, which according to the clinical manager includes the need for the resident to be accompanied by a family member, or a staff person. A registered nurse informed that a copy of key, specified assessment, care plan and medication records accompany the resident. A reassessment process is undertaken on return to the facility.
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 are documented policies, procedures and safe practice guides for all aspects of medicine management. The service has a contracted pharmacist that assists with keeping the service informed of any changes in legislation, protocols and best practice guidelines. There are no standing orders used, with all medications individually prescribed for each resident. The service has a stock of impress medication for administration of medications. The medications, including controlled drugs, are securely stored. The controlled drug register recorded daily checks, weekly stock count check and a six monthly quantity stock count. The medication fridge temperatures were recorded at least weekly. It was noted that some medication fridge recording were below the recommended guidelines, though this is not reflective of a systemic issue, with actions implemented to address any temperature records that fell outside the guidelines. The content of the medication charts complied with legislation and best practice guidelines. Medication management is discussed with the resident on admission, when changes occur and prior to discharge. Any changes in medication are communicated to the resident's GP. When medication errors occur, there are processes for incident reporting and staff evaluations and learning from any errors. All staff that assist in medicine management are assessed as competent to perform the role, this includes general medication procedures and competency assessments for subcutaneous medications. There are mandatory medication learning modules for the nursing staff. The medication competency assessment and education is conducted at least annually. Self-administration of medicines is not usually undertaken by the residents at hospital level of care. There are processes in place for the prescriber to assess if the resident is competent to self-administer their medications. A locked box is used to store the patents medications securely in their room. A medication round was observed in one of the hospital wards and required protocols were maintained. Twelve medicine records were reviewed and prescribing and sign off are meeting the medication guidelines and relevant legislation.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual	FA	The nutritional services are provided by a contracted catering provider. All food is prepared and cooked in the onsite kitchen. The menu has been reviewed six monthly by a dietitian as being suitable for the older person living in long term care. The service has a four week rotational menu with seasonal variations. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified

food, fluids and nutritional needs are met where this service is a component of service delivery.		nutritional needs or specific diets have these needs met. Residents did report some dissatisfaction with the variety of food on the menu, though report overall satisfaction with the food and fluids provided. The kitchen has an approved food safety plan. All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. Fridge and freezer recordings, undertaken daily, meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates and ongoing education through the catering company.
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 stated that the Nurse Maude Hospital does not have a policy of having a waiting list and that residents requesting admission are prioritised by their needs and bed availability. She also informed that if there are no hospital beds available then any potential residents and family/whanau are advised about Eldernet's vacancy records, about possible options in the area, or recommends they speak with their GP or needs assessment service unit. Palliative care is provided to all residents in the hospital, however the clinical manager informed that potential residents who require palliative care have at times been declined due to available resources or staffing at a given time and in such instances will be referred back to the social worker or referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Policy and procedures are available for pain management, adult continence, personal hygiene and grooming, skin integrity and pressure management and wound management. All include an assessment component with associated forms and tools. A range of completed assessment tools that are used routinely were evident in the personal files of the residents. These included InterRAI assessment records, a comprehensive initial nursing assessment that is repeated at the six monthly review timeframe, a Braden Scale for pressure areas and a falls risk assessment, which is progressed to a multi-disciplinary falls risk form when indicated. Additional assessment tools sighted in residents' files that are used when an issue is highlighted in referral documents, or in the nursing assessment, included ones for diabetes, pain, behaviour and nutrition.
Standard 1.3.5: Planning Consumers' service delivery plans are	PA Moderate	The personal files of seven residents, including the tracer's, were fully reviewed and the sample extended to ten to verify the findings. The personal files demonstrate that assessment processes are informing the long term care plans. Each person has a set of problems/nursing diagnoses. The problems all have a personalised goal against them as well as a set of interventions, which provide associated care and support instructions. Personal

consumer focused, integrated, and promote continuity of service delivery.		files also include short term care plans for problems such as urinary tract infections, respiratory infections and skin tears as well as allied health plans such as physiotherapy assessments and interventions. Personal profiles and activities plans sit alongside these plans as do the medical notes for the monthly and as needed GP visits. The accuracy and currency of the interventions in some files require improvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents, including the tracer, family members and volunteers who were interviewed consistently provided favourable reports about the level of care and support provided to residents. All acknowledged how busy the staff are but also stated that the 'staff are wonderful'. They thought that all of the main needs of the residents are being met, that any adverse situation that arises is dealt with immediately and none of the people interviewed had a complaint about the services delivered. Seven sets of progress notes were reviewed and these show that the care provided is consistent with the residents' goals, the nursing diagnoses and interventions in the care plans.
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	A diversional therapist is responsible for the activities programme. She is currently undertaking training which combines foundation studies and diversional therapy modules. Activities are formally available on five days of the week. A project called Te Ora has been developed and continues to be implemented to ensure the activities programme is personalised and meeting the holistic needs of residents. A personal profile that covers the resident's past and present interests and activities, family information and personal history is developed within three weeks of admission. All personal files sighted, except for a recent admission, have a completed profile. The diversional therapist informed she asks family members to complete this with the resident but where this is not successful she will complete it with the person. Activities goals are developed from the information obtained. Personal interests of the current residents are integrated into the wider programme and/or personal programme when one-on-one activities are undertaken with the resident. Volunteers and family members are encouraged to help with this aspect. A flexible monthly programme is developed and was on display. This includes a diversity of activities that have cognitive, creative, physical, domestic, external and/or spiritual dimensions. Progress on residents' activities goals are included in their progress notes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely	PA Low	Multi-disciplinary team reviews occur every six months for each resident. Records of these state who was present at the meeting and anyone else who contributed to the review, such as nurses, caregivers, physiotherapists, the diversional therapist, the GP. The residents and family/whanau are invited to contribute to these reviews. Goals for each identified problem in the care plan are numbered and comments on each are documented on a separate sheet according to the number of the goal. The comments reflect the level of progress for each, they are individualised and suggest options for ongoing care. Ongoing reviews of short term care plan problems are recorded in progress notes. An area for improvement is that interventions in long term

manner.		care plans are amended when identified as necessary following evaluation processes and that reviews are recorded against short term care plans to demonstrate the progress towards resolution.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	A referral management and administration policy is in the quality manual. Copies of referrals to other health and disability services were evident in the personal files of residents that were reviewed during the audit. Examples include to dietitians when a change to a person's eating pattern occurred, dental services through the District Health Board dental services and specialist consultancies through the GP. The clinical manger noted that as an organisation Nurse Maude has a range of outpatient services such as continence advisory service and specialist wound care, which the registered nurse may refer a resident to if additional expertise is required. Examples of such referrals were also viewed.
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	Waste is managed based on general, recyclable, and hazardous category. There are three separate waste collection points on the main site at McDougall St, one for general waste which is a large skip, a recyclable site for glass, plastics and cardboard (the bins are colour coded for each material) and this area is fenced and padlocked after hours. There is a sharps yellow bins collection area which is in a locked caged area located away from public access and within security access area of the main Nurse Maude site. Within the Nurse Maude staff only area, only clinical staff are able to access the caged area itself. Within the facilities the infectious yellow waste bins have lids and are pedal operated. Bin bags are labelled and colour coded for easy identification. Infectious laundry are bagged in yellow bags and laundry staff don PPE (mask, gloves and apron) when dealing with infectious laundry. Chemicals are labelled and stored appropriately in both the laundry and clinical areas. PPE is available where hazardous waste is handled. General waste is collected by a cleaner and another staff member whose job is to collect general waste throughout the day. Consequently general waste bins are never full. All waste is then removed from the site by a contracted service. An initiative has seen the recycling of continence waste which is processed and transformed into garden manure. Staff are aware of hazardous waste management procedures, and responding to spills and exposure to hazardous material. Staff training and awareness is initiated at orientation. A dedicated Infection Control nurse ensures practices are maintained including undertaking regular reviews of infection control policies and procedures. In the clinic area there is a dedicated health and safety notice board that holds all relevant information, including newsletters, minutes of the health and safety committee meeting, hazard register and accident and incident forms. Policy and procedures for hazardous waste is covered in the Infection Control Manual and organisation policies.

		Organisational waste management practices are also contained in the Occupational Health and Safety policies and cater for contractors and sub-contractors. There is evidence of an environmental friendly approach to Nurse Maude waste management procedures where recycling is carried out where appropriate as well as waste reduction such as monitoring kitchen food waste.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The environment is appropriate for residents' needs and includes regular maintenance and checks of the physical environment and equipment. Placement of furnishings enables a good level of space for movement by foot and wheelchair. External disability access is located at the main office building and service delivery areas. There are internal lifts in the clinical service areas to enable internal disability access. Doors and access ways are clear and appropriate signage are in place to clearly indicate exits. There is very good level of signage throughout all buildings (both externally and internally) to indicate health and safety hazards (eg, hot water, dust and noise area, slippery ramps). Cones are placed in the carpark to direct vehicles and provide a cordon around temporary office areas located in the carport area. The main site consists of a number of buildings both temporary and permanent. This is a result of the rebuilding due to the Christchurch earthquakes. There is also construction work occurring and this is appropriately segregated and managed in accordance with Worksafe NZ requirements. Debris from the site is monitored and appropriate health and safety action taken as required (eg, work ceased when windy). There is a comprehensive maintenance schedule which is contracted to a single service provider who oversees all testing and inspections of all equipment, reticulation and plant through sub-contractors. These inspections include building warrant of fitness compliance. In addition the Nurse Maude site development manager and site coordinator undertake daily and weekly checks of the buildings, equipment and general environment. The schedule accommodates both routine and reactive maintenance and repairs. There are after hours contact numbers displayed in the hospital nurses station. Monthly inspection reports are provided to Nurse Maude. The maintenance schedule includes as an example, the inspection of emergency lighting, fire extinguishers, safety barriers, air and water purity, boiler LPG, door servicing, filters, laundry driers, refrigerator temperature.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are	FA	A number of resident's rooms have their own ensuite. There are a small number of rooms that share a toilet and shower between. Two of these rooms are used for respite care. The toilet and shower areas enable good level of movement and space and are equipped with call buttons (corded) at both the toilet and shower. The ablution area is equipped with sprinkler, ventilation and speaker (for alarm).

assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
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	The rooms provide a reasonable level of personal space and are nicely furnished. Residents are able to have personal items on display and where appropriate own furnishings.
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	The hospital is on two levels. The recreation and dining areas are separated and are nicely furnished and decorated. Downstairs there is a small outdoor area. There is good light that comes through windows in the communal areas. There is also a designated reading area with assortment of books and toys. The effect is welcoming and relaxing.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The on-site laundry service is a contracted service (staff and practices). Detergents are supplied by Ecolab who also provides maintenance on the equipment. The four industrial grade washing machines are equipped with visual data screens that are able to be analysed by a technician. They are also equipped with emergency stop buttons. Three types of detergents enter the system through electronic controlled piping to the washers. The level and mix of detergents is dispensed based on a formula that pre-selects the mix of detergents depending on the wash cycle selected and is appropriate to the type of wash selected. The wash cycles include linen, personal, soiled and infectious. The service is internally audited. The inside laundry area is separated into dirty and clean. Laundry bags are delivered by staff to a designated area immediately outside the entrance to the dirty area. The linen bags are coloured coded for personal, soiled, linen and infectious. The bags are retrieved by the laundry staff who wear

		gloves and aprons; the bags are weighed and recorded before being put into the washer. There is safety signage on how to respond to chemical contact on the person. The overall room environment; noise and temperature, was within normal comfort range. The chemicals (detergents) are stored in a lockable cupboard and were clean and tidy with the chemicals stored on shelves off the ground. There are corresponding material safety data sheets (MSDS) for the various detergents.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are good emergency and security systems that support the wellbeing and safety of staff and residents. There is a fire alarm system and emergency call button for staff located in the reception area. Nurse Maude operates a contracted security service which provides site inspections, and emergency response according to set protocol. External access is fitted with security swipe card system. After hours the doors are automatically locked and including the windows are alarmed. Back up utilities systems are in place for power, oxygen and water. The back-up power system is automated while the on-site water tank requires to be plumbed but is assessed as a simple task. Staff are trained and trial evacuations occur twice a year though actual resident evacuation is not undertaken. Staff are aware of how to respond in various types of emergency be it medical, security or disaster. Emergency and after hours contact numbers for equipment, security, emergency services as well as the duty manager number are clearly displayed on signage in the nurses station. Smoke and fire alarm electronic boards enable clinical staff in the hospital to identify the specific location of the incident.
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	All residents' rooms have windows that let in a reasonable level of natural light. There is a maintained ventilation system in the shared hospital and hospital facilities. These are monitored by staff and compliance checks conducted by a contracted service provider.
Standard 3.1: Infection control management There is a managed environment, which	FA	Responsibility for infection control is defined and there are clear lines of accountability for infection control matters in the organisation leading to the clinical governance team. There is a monthly infection control committee meeting which is part of the health and safety meeting. The infection control coordinator has a job description for the infection prevention and control role.

minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		The organisation has a documented infection control programme that has been reviewed at least annually (last conducted in December 2014). The infection control meeting minutes confirmed that the programme was last reviewed in December 2014. This review included education, infection control resources, internal audits, surveillance activities and annual reporting against the plan. Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. Staff are asked not to come to work if they are unwell. Family/whanau are encouraged not to visit the resident if they are unwell. The service has sanitising hand gel available for all staff, residents and visitors to use.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has access to specialist infection control advice through the external microbiologist and DHB when extra advice is required. The infection control coordinator has knowledge of current practice.
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	FA	There are written policies and procedures for the prevention and control of infections which complies with relevant legislation and current accepted good practice. The infection prevention and control policies and procedures are reviewed by the designated infection control personnel, the quality team and the clinical governance teams. Staff demonstrate knowledge on infection prevention and control practices.

appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education is provided by the infection control coordinator and other clinical team who maintain their knowledge of current practice. The infection control coordinator demonstrated knowledge of current accepted good practice and has completed relevant ongoing education. Online research on current accepted good practice and using national palliative guidelines were referenced in the education material. Infection prevention and control education is conducted at the training days. Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. The infection control team report that this may be done informally with residents and their family/whanau, such as when a resident has ongoing issues with infections.
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	The surveillance policy identifies that the service monitors infections that are based on palliative and community guidelines. This is appropriate in maintaining a homelike environment in the long term care facility. Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. Where trends are identified, actions are implemented to reduce the re-occurrence of infections.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Nurse Maude has a policy that clearly outlines their preference for the non-use of restraints. Comprehensive policy and processes are in place should there be a requirement for the use of restraints. This clearly outlines when, what, and why restraints maybe used. Staff interviewed were able to knowledgeably articulate the policy and procedures including definition of restraint and enablers. At the time of the audit there is one resident using two types of restraints (bedrails and lap belt). There is one resident using an enabler (bedrail). While staff and the resident have discussed the requirement for and the use of an enabler and there is monitoring as to the ongoing requirement for the use of the enabler; this was not recorded in the care plan (refer to 1.3.5.2).
Standard 2.2.1: Restraint	FA	There is a comprehensive policy and processes for assessing and approving the use of restraints. Assessment

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.		includes other intervention strategies. All use of restraints is approved by the Restraint Coordinator.
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 assessment process where alternative strategies that include attending to the residents comfort, for example more toilet breaks, quiet time and physical interventions such as lowering the bed, placing sensor mats or mattresses next to the bed. These are trialled before any consideration of restraint use is undertaken. When a restraint assessment is made the pros and cons are considered and recorded. The assessment is undertaken by a care team that includes the doctor, nursing staff and restraint coordinator. The assessment will also include the client (and or family member). Resident consent is sought and if this is not possible from the resident, then it is gained from a designated EPOA.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	There is a comprehensive assessment process where alternative strategies are trialled before any consideration of restraint use is undertaken. When a restraint assessment is made the pros and cons are considered and recorded. The assessment is undertaken by a care team that includes the doctor, nursing staff and restraint coordinator. The assessment will also include the client (and or family member). Where relevant a psychogeriatric specialist clinical nurse input may be sought as part of the clinical assessment process. There is one resident using restraints at the time of the audit with staff carrying out the restraint processes appropriately.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	During the assessment for the use of restraint a review period is pre-determined by the clinical team and this is either monthly or three monthly. The resident who is currently using restraints is on a three monthly review and the first review is due in November. Staff record the use of restraint every 90 minutes and this monitoring record is checked by the restraint coordinator each week.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Monthly reports compiled by the restraint coordinator show the total number of hours of restraint use over the month. This report is provided to the quality and risk committee and is chaired by the director of nursing. In addition a six monthly report that shows restraint usage over this period is also provided to the committee for evaluation. Staff training is conducted every two years and on induction for new staff. There is a concerted effort to minimise the use of restraints in accordance with policy and this is reflected in the low numbers of residents on restraints.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.	PA Low	During interview, residents were unaware of their rights, and relatives who had accompanied hospital residents during admission could not recall being told about them and were not familiar with them. Staff stated that people are provided with a copy of the brochure to read at their leisure as so much else happens at admission and they are provided with so much information. They also confirmed that updates are not currently being provided for long term residents and/or relatives.	Opportunities to explain, discuss and clarify the Health and Disability Commissioners Code of Health and Disability Services Consumers’ Rights (the Code) are not occurring and the residents and family members interviewed were not familiar with them.	Residents and family members/whanau are informed about the Health and Disability Commissioners Code of Health and Disability Services Consumers’ Rights (the Code). 180 days

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.	PA Low	Mandatory training requirements are defined for the different roles. Requirements and timeframes have recently been reviewed. All necessary topics are covered. The Clinical Nurse Manager maintains a spreadsheet of training completed and there are individual training records also maintained. It is not possible to easily determine from the spreadsheet who has completed requirements and those outstanding. The Clinical Nurse Manager interviewed was unable to confirm that all requirements have been met, reporting that this probably varies from between 75% (restraint minimisation and safe practice, managing challenging behaviours, and infection prevention and control) and 100% (cardiopulmonary resuscitation (CPR) and 'moving and handling'). All performance appraisals have been completed. Staff interviewed felt well supported with the training opportunities provided.	The mechanism for recording of mandatory training requirements does not support a process to easily determine if all staff have completed requirements. According to the Clinical Nurse Manager not all staff have completed all requirements.	Staff complete all required training within the specified timeframes and there is a mechanisms to easily monitor this. 180 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Service delivery plans generally describe the required support and/or interventions, however four files do not have information updates following evaluation and the short term care plans do not show any changes to interventions or if/when resolved. These issues have been raised for corrective action under criterion 1.3.8.3. In addition there were gaps identified in 50% of the initial care plans, before the sample was extended. Although most of these appeared to have resulted from errors made during the rewriting of the plans with some problems not transferred over, or duplicate issues with the problems written differently, it did mean that not all of the service delivery plans were accurate and current.	Not all service delivery plans describe the required support and/or interventions, with one file not mentioning use of an enabler and rewritten care plans in three files have examples of duplicate problems, or do not include some previous problems and interventions.	Service delivery plans will describe the required support and/or interventions according to the personal goals and information obtained from ongoing assessments. 90 days
Criterion 1.3.8.3 Where progress is different from	PA Moderate	There are examples in four of the ten care plans reviewed where one or more of the most recent evaluation comments showed that the needs of the resident had changed. However these changes are not consistently being transferred onto the long term care plan. Also, the reviews of	Required changes that have been identified during evaluation processes	Changes are made to the interventions in long and short

expected, the service responds by initiating changes to the service delivery plan.		problems identified on short term care plans are being included in progress notes and it is not possible to see at what level the problem was resolved, or if/when the problem was transferred onto the long term care plan. The comprehensive nature of the progress notes mitigates the overall risk of this issue.	are not always being made to the interventions in the long and/or short term care plans.	term service delivery plans when progress is different from expected. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.