

Auckland Presbyterian Hospital Trustees Incorporated

Introduction

This report records the results of a Surveillance 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:	Auckland Presbyterian Hospital Trustees Incorporated
Premises audited:	St Andrew's Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 November 2015 End date: 19 November 2015
Proposed changes to current services (if any):	There has been a reconfiguration of services. Ten rest home beds have been converted to dual purpose beds.

Dedicated rest home beds have been reduced from 40 to 30 and dual purpose beds have increased from 10 to 20.

Total beds occupied across all premises included in the audit on the first day of the audit: 166

Executive summary of the audit




Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Andrews is owned and operated by Auckland Presbyterian Hospital Trustees Incorporated. It provides care for 30 dedicated rest home residents, 30 secure dementia care residents, 100 dedicated hospital level care residents (three are dedicated palliative care beds) and 20 beds are dual purpose beds catering for either rest home or hospital level care residents.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management, staff from across all services and one general practitioner.

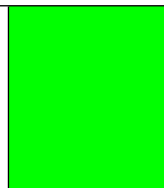
The facility recently converted 10 dedicated rest home care beds to dual level care beds, therefore some additional environmental criteria have been reviewed.

Human resource management is a strength of the service and this is reflected in the report findings. There were no areas identified for improvement in the previous audit. At this audit, two areas for improvement were found relating to assessments and restraint, rated as low and moderate risk respectively. The service provider does not agree entirely with these areas for improvement.

Feedback from residents and family/whānau members was positive about the care and services provided.

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.



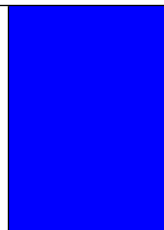
Standards applicable to this service fully attained.

Staff communicate effectively with residents and family/whānau in an open and honest manner. Appropriate processes are in place to guide staff to access interpreter services if required.

St Andrews implements policy and procedures to ensure complaints are documented, reviewed, followed up and fully addressed. At the time of audit there were no open complaints.

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.



All standards applicable to this service fully attained with some standards exceeded.

The business plan for St Andrews covers all aspects of service delivery planning. This identifies key objectives and shows the strategies put in place to reach set goals. Goals are resident centred so that their needs are met. The business plan is fully reviewed and updated at least annually at board level.

All aspects of the service are overseen by the management team in place who meet regularly with the Chief Executive Officer (CEO) and all relevant information is shared with the board as appropriate. The clinical team is led by two clinical managers who are both registered nurses.

The service has a comprehensive quality and risk management system in place as described in policy and is understood by staff. Quality management reviews include an internal audit process, complaints management, satisfaction surveys, resident meetings and quality data collection. Quality data collected includes incident/accident, falls, skin tears, pressure area and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau as appropriate.

The day to day operation of the facility is undertaken by staff who are experienced in aged care. Education is put in place and monitored to ensure all compulsory education is undertaken annually by staff. Regular on and off site education occurs. Staff who work in the dementia care area hold specific dementia care qualifications. All shifts are covered by more than one staff member who holds a current first aid certificate. The human (HR) resource practices are auditable, regularly reviewed, closely monitored and evaluated by the HR manager and at governance level. This is an area of particular strength for St Andrews.

As confirmed during resident and family/whānau interviews, residents' needs are met.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service promotes a team approach to care delivery and is coordinated in a manner that promotes continuity. Services are provided by suitably qualified and trained staff. All internal assessments of residents' needs are completed using the electronic interRAI assessment programme. However, an improvement is required in the processes for assessment, planning, provision, review and exit to ensure that documentation is provided within time frames that safely meet the needs of the resident and meet contractual requirements.

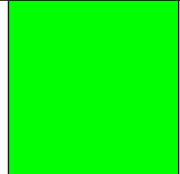
Care is evaluated at least six monthly, or sooner if there is a change in the resident's needs, in which case, a short term care plan is implemented; however, an improvement is required in the Dementia unit to ensure that the behaviour care/challenging behaviour care plans are supported by appropriate and relevant assessment tools.

Residents are encouraged to maintain links with family and the community. The activities that the service provides within the rest home reflect this.

A safe medicine administration system was observed. Staff responsible for medicine management have been assessed as competent to do so.

The residents were satisfied with the meal service. The menu has been reviewed by a dietitian and residents' nutritional requirements, preferences and needs are met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service maintains all practices to ensure the requirements for their building warrant of fitness are met. The service is now using 10 beds which were previously dedicated rest home care beds as dual use beds. This allows either rest home or hospital level care residents to occupy these beds. The bedrooms, equipment and staffing levels allow safe dual bed use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There are 22 residents who have either restraint and/or enablers in use. Enablers are described in the policy as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

At the time of audit the restraint register showed the type of restraints in use. This is an area identified for improvement and as a result, the number of criteria audited was increased.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are 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	1	20	0	1	1	0	0
Criteria	2	47	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Complaints management is implemented to meet policy requirements. The complaints register sighted identified the issue, the date received and the date the complaint was closed off. Complaints follow-up was clearly documented and all complaints have been closed off. Two complaints received were deemed by the organisation as being very serious and the organisation was pro-active and alerted the DHB. Following a DHB review no further follow up was required. No complaints have been taken off site by either the resident or a family/whānau member. There are no open complaints at the time of audit.</p> <p>Documentation sighted relating to complaints follow up includes detailed corrective actions. Management confirm all information gathered around complaints is used as an opportunity to improve services as required. Management and family/whānau interviews confirmed that complaints management was explained during the admission process. Staff verbalised their understanding and correct implementation of the complaints process.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Families/whānau members interviewed reported that communication is undertaken to reflect the principles of open disclosure. Contact with family/whānau is documented on the incident and accident forms and in the resident progress notes. This was confirmed in the ten resident files reviewed.</p> <p>The service has policy and procedures related to use of interpreter services and this is fully described in the resident information discussed upon admission.</p> <p>Staff demonstrated knowledge related to the sharing of full and frank information in an honest and open manner.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Business planning is undertaken at executive level with input from all levels of staff across the organisation. The quality management framework clearly identifies the organisation's commitment to including all health care services, staffing and meeting the needs of residents and family/whānau. Both the business and quality plans are reviewed throughout each year to measure achievement. The organisation's goals and direction are clearly described and match the organisation's mission, vision, values and strategies put in place to assist all resident needs to be met.</p> <p>On the day of audit there were 107 hospital, 29 rest home and 30 dementia level care residents at the facility.</p> <p>The organisation's clinical governance and risk management is undertaken by staff who are suitably qualified for their roles. The on site management team of managers is led by the CEO with HR, quality and risk, facility, kitchen, administration and two clinical nurse managers all being part of the support team. All actions are overseen and monitored by a board of trustees. Job descriptions sighted identified the authority, accountability and responsibility for the provision of services for each role. Staff educational records identify that all managers maintain ongoing education relevant to the role they undertake.</p> <p>Interviews with residents and family/whānau members confirmed that their needs were met by the service.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management system documented is understood and implemented by service providers. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording, off-site benchmarking and complaints management processes. If an area or deficit is found, corrective measures are put in place to address the situation. This process is well documented. Information is shared with all staff as confirmed by information sighted on each staff notice board, in meeting minutes and verified by staff during interview.</p> <p>Information gained by the quality processes undertaken is used across all services to inform ongoing service planning and to ensure residents' needs are being met. St Andrews identifies how corrective measures are managed by being overseen by the most appropriate committee or person. Corrective measures sighted are evaluated and signed off if they are successful and add benefit to service provision. For example, during one complaint follow up it was deemed that a better handover of information process could be developed for each clinical shift. Currently this new process is being trialled and evaluation information will be taken to the clinical quality and risk monthly meeting. A clear auditable trail is documented.</p> <p>St Andrews maintain a quality improvement register which is a working document and identifies each stage of corrective actions and/or quality projects which are being undertaken. Senior staff report against required outcomes.</p> <p>There is a system in place for the update and introduction of policies and procedures. This is all managed via the quality and risk office and all policies and procedures are accessible to staff on the intranet and in hardcopy. All updated policies are emailed to all areas so staff are aware of any changes. This is discussed at each house (ward) level meeting as confirmed in minute meetings sighted.</p> <p>Actual and potential risks are identified and documented in the risk register which covers all aspects of service provision. Newly identified hazards are documented using a specific form to show how the hazard is managed. Hazards are overseen by the health and safety committee who meet monthly. Hazards are communicated to staff, family/whanau and residents as appropriate. Staff confirmed that they understood and implemented</p>
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		<p>documented hazard identification processes.</p> <p>Residents and families/whānau interviewed confirmed they are very happy with the services provided. Staff verbalised quality improvements and how they have been embedded into everyday practice.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policy is implemented related to all adverse events being recorded on incident and accident forms. There is a nominated pathway for the review of all adverse event forms and this includes being documented electronically, going through the quality and risk office and to the quality management meetings as required. All incident and accident forms sighted had been reviewed and completed in a timely manner. For example a resident who had a fall and complained of pain was x-rayed the same day. Nothing was found but the resident still complained of pain so two days later a magnetic resonance imaging scan (MRI) was undertaken showing an injury. All process including appropriate notification and the sharing of information with family/whānau is clearly documented. Staff interviewed confirmed they report and record all incidents and accidents.</p> <p>Documentation confirms that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Falls are reviewed at staff and management meetings and information is collated to identify if any injuries were sustained or if there are any common trends. All events are fully investigated and reviewed to ensure corrective actions required are in place to assist a positive outcome. Senior staff understand their obligations in relation to essential notification requirements which are clearly shown in policy.</p> <p>Family/whānau members interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relative. This was supported during a review of incident and accident forms and residents' file reviews.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	CI	<p>Having fully attained all criteria for this standard, the service can also clearly demonstrate review processes which include analysis and reporting of findings leading to improvements being made based on the findings. The HR management systems have been fully reviewed and updated to ensure</p>

<p>requirements of legislation.</p>		<p>staff are prepared, educated and understand how to offer services to meet resident needs. A comprehensive orientation system is in place which ensures residents needs can be met. Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation.</p> <p>The service has an annual education calendar in place which covers all aspects of care, including emergency management processes. Staff have the opportunity to attend off-site seminars and training days to ensure all aspects of service provision are met. This was confirmed in the education records sighted in staff files.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy identifies that adequate numbers of suitably qualified staff are on duty to provide safe quality care including staff who work in the dementia care unit holding approved qualifications.</p> <p>A review of the clinical rosters showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents' needs are met. This is supported by resident and families/whānau interviewed.</p> <p>There is always a member of the senior management team available on call. All shifts are covered by a minimum of two registered nurses.</p> <p>There are dedicated activities, kitchen, laundry, maintenance and cleaning staff.</p> <p>Other areas which have dedicated staff are HR, education, quality and risk. These services operate Monday to Friday.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medicines for residents are received from the pharmacy and are in a pre-packed delivery system. An electronic medication management system has been implemented. Safe medication management procedures were observed on the day of audit. Medication charts reviewed on the electronic system complied with legislation and aged care best practice guidelines. All medication files reviewed had been reviewed by a general practitioner in the last 3 months. The medications and medication trolleys were securely stored in the rest home, hospital and dementia units. Medicines that require refrigeration are stored in fridges dedicated to medications and daily temperature recordings were sighted. The controlled drugs are managed to meet legislative and aged care guidelines. There were no residents self-medicating at the time of audit. All non-used medication is documented and sent back to the pharmacy.</p> <p>There are documented competencies sighted for the staff (registered, enrolled nurses and health care assistants) designated as responsible for medicine management. The registered nurse administering medicines at the time of the audit demonstrated competency related to medicine management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a four week rotating menu throughout the summer and winter season. The menu is created in discussion with residents and then reviewed by a dietitian. When unintentional weight loss or weight gain is recorded, the resident is discussed with the GP and referred for a dietitian review. Pureed and minced options are available including an alternative choice of the main daily menu option.</p> <p>A nutritional profile is completed for each resident by the registered nurse upon entry to the service and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. Residents have access to food/beverages and nutritional snacks 24 hours a day. A snack and coffee machine are located in the main reception area and water coolers are situated throughout the facility.</p> <p>To promote socialisation and safety, residents in the rest home are encouraged to have all meals in the dining room. Residents in the hospital and dementia units have breakfast in their rooms and are encouraged to</p>

		<p>have all other meals in the dining room. If a resident chooses to have their meals in their rooms a registered nurse will discuss with the resident and family any concerns that either party may have and a waiver form is signed acknowledging what has been discussed. All meals are cooked on site in the kitchen and delivered to the dining rooms by mobile heated transport systems. Family/whanau and residents interviewed reported that they are satisfied with the meals provided.</p> <p>Regular monitoring and surveillance of food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal were sighted at the time of audit. All fridges and freezers had temperature recordings sighted. Kitchen staff have undertaken food safety management education appropriate to service delivery.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Rest home and Hospital and Dementia unit: The care plans reviewed were individualised and reflected the resident's assessed needs. This could be done in greater detail in relation to managing challenging behaviour: refer to comments in 1.3.3.3.</p> <p>The residents and family/whanau reported that the staff have excellent knowledge and care skills. The GP expressed satisfaction with the care provided and reported that staff were highly skilled and professional in their approach. The provision of services and interventions was consistent with, and contributed to, meeting the residents' assessed needs and desired outcomes. The care plans reviewed were individualised and personalised to meet the specific assessed needs of each resident. The care was flexible and focused on promoting quality of life for the residents.</p> <p>Residents and family/whanau interviewed reported high satisfaction with the care and service delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on events that are organised within the facility and surrounding communities. Regular activities include discussing current affairs, church services, van outings, specific men's and women's groups, arts and crafts, happy hour and regular</p>

		<p>weekly entertainment.</p> <p>The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The diversional therapists and activity coordinators adapt activities to meet the needs and choices of the resident. Residents have access to a home-like kitchen setting environment within their areas of living and residents are encouraged, supported and supervised by staff and family to maintain daily activities of living.</p> <p>The daily and monthly activities plan sighted was developed based on the residents' needs, skills and strengths and is developed in discussion with residents. The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and are assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file six monthly.</p> <p>The service provides easy access to outside courtyard areas.</p> <p>Dementia Unit:</p> <p>Family members of two residents interviewed reported they are welcome and supported when visiting their family member and encouraged to participate in planned activities. The Dementia unit is supported by a diversional therapist six days a week. Staff reported that activities are organised by activities staff and are available and accessible for all staff in the evenings as required.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are documented at least six monthly. When there are short term care plans, these interventions are evaluated more frequently. The wound treatment plan sighted had an evaluation of the treatment and condition of the wound at each dressing change. All the long term care plans sighted were developed, reviewed and evaluated in the last six months.</p> <p>Where progress was different from expected, the service responded by</p>

		<p>initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed.</p> <p>The residents and family/whanau reported high satisfaction with the care provided at the service.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Documentation identifies all processes are maintained for the facility's current building warrant of fitness which expires on 30 June 2016. There have been no changes made to the footprint of the building since the previous audit. However there has been a change in bed status and now 10 beds which were originally dedicated rest home are being used as dual purpose and can have either rest home or hospital level care residents. The service has appropriate equipment which is maintained on a regular basis. Many of the bedrooms have ceiling hoists to aid the transfer of residents safely. As hospital services are already being offered, all equipment is in place.</p> <p>The facility is set on very large grounds with appropriate shaded, furnished outdoor areas for resident use.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate toilet and bathroom areas. The ten bedrooms being used for dual purpose have full ensuites which are large enough to use lifting equipment safely if required.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The ten bedrooms being used for dual purpose are all single occupancy and of a size which allows staff to use equipment safely.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	<p>The infection coordinator completes monthly surveillance of infections and uses standardised definitions of infections that are appropriate to the long term care setting. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease,</p>

<p>specified in the infection control programme.</p>		<p>trends and actions taken to reduce infection. Trends and/or concerns within a particular unit and/or within the facility and specific resident/s are identified and these are discussed at staff meetings, staff handovers and tool box sessions are provided where additional actions are discussed and implemented. In promoting these tool box sessions trends show that there has been a marked reduction in urine infections within the different units of the facility. Benchmarking of surveillance data occurs with the other providers of aged care facilities.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy identifies that the use of enablers is voluntary and the least restrictive option to meet the needs of the resident. St Andrews has bedside rails in use as enablers at the time of audit. Two files reviewed for enabler use identified appropriate assessments are undertaken and enablers are consented for and appropriate monitoring is undertaken.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>PA Moderate</p>	<p>The process and approval for restraint is clearly shown in policy. However, policy indicates that personal restraint can be used in the dementia care unit. This is not best practice and is an area identified for improvement.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The assessment forms being used cover all necessary criteria to meet this standard. All 22 residents who have approved restraint have an assessment undertaken by the RN. This information is then taken to the restraint committee for approval of restraint. Whilst possible alternative interventions and strategies are shown on the care plan it would be best to have a behaviour monitoring chart in place to show if any of the strategies were successful. Refer comments in 1.3.3.3.</p> <p>When this was discussed with the nurse managers and senior management staff, they said that expert assistance had been sought and they had been advised that behaviour charts are not always required for residents who</p>

		have mental health input.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Restraint is used as a last resort. The restraint register shows sufficient detail to identify what restraints are in use and how long they have been in use. There have been no reported incidents or accidents related to restraint use. This was confirmed by the restraint coordinator and in meeting minutes sighted.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The use of restraint is evaluated at least three monthly or on an as needs basis. All aspects of this standard are used in the review process. Family/whanau and the resident as appropriate are involved in the approval and evaluation of the restraint in use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service demonstrates that monitoring and quality review of their use of restraint is undertaken three monthly. This is reflective of the changes made to policy related to the use of personal restraint as described in standard 2.2.1. Staff interviews confirmed compliance with policy and procedures and that annual education is compulsory for clinical staff. Attendance is closely monitored by HR. Refer comments in standard 1.2.7.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Assessments to identify behaviours over a 24 hour period or strategies for minimising challenging behaviours were not sighted. Family/whanau of residents living in the memory loss unit reported that staff are aware of residents' individual needs and challenging behaviours are managed appropriately. Staff interviewed were able to report interventions for individual residents to reduce and minimise risk.</p> <p>InterRAI assessments for all residents were not evidenced. Note: Evidence was sighted showing that requests for a certain number of those residents had been made and awaited transfer and information to be entered into the facility's interRAI system by the District Health Board.</p>	<p>Two of two files reviewed in the dementia unit did not have challenging behaviour assessments and associated plans that documented: i) strategies for minimising challenging behaviours; and ii) a description of how the behaviour is managed over a 24 hour period, as required in the ARCC E4.3b.</p> <p>One person has had a behavioural assessment, however other than the care plan stating that two staff were to manage the resident's aggressive behaviour and stating two staff are to hold the resident for a shower or to wash them when required there was no behaviour management plan to guide staff in de-escalation or techniques to manage this person.</p> <p>Staff interviewed stated that these</p>	<p>Ensure that there is a behaviour management plan in place to guide staff on the techniques to de-escalate behaviour and the management of residents who demonstrate aggressive behaviour.</p> <p>Ensure that all residents are entered into the facility's database and that all interRAI assessments are completed within required timeframes to meet policy and contractual requirements.</p>

			<p>assessments are only used on initial admission for a resident.</p> <p>A number of interRAI assessments do not meet required timeframes and are at least two months overdue.</p>	180 days
<p>Criterion 2.2.1.1</p> <p>The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	<p>PA</p> <p>Moderate</p>	<p>The responsibility for restraint process and approval is clearly defined in policy. The accountability for restraint use is clearly defined. Policy includes personal restraint which allows a staff member to physically hold a resident therefore preventing them from free movement. Policy states "This is only used in extreme circumstances with clinical manager approval. Two of three resident files reviewed who had approved physical restraint identified the need for physical restraint occurs at least three weekly. Staff stated during interview this process has been approved by the psycho-geriatrician from Auckland District Health Board Mental Health Services for Older Persons. The restraint policy defines the use of medication to manage residents behaviour as 'chemical restraint'. Under the definitions provided by the Health and Disability Services Standards, this does not constitute 'chemical restraint'.</p>	<p>The service has three residents approved for personal restraint. Discussion with RNs who work in the area and documentation sighted in two of the three residents both residents' progress notes showed that personal restraint is used at least once every three weeks. (Refer comments in 1.3.3.3 related to no 24 hour behavioural management charts being sighted). This involves staff members physically holding the resident to allow personal cares to be undertaken if the resident requires a shower or personal cares such as a 'wipe-down'. Staff and documentation confirm this process has been approved by the EPOA and specialist advice from the Mental Health Service for Older People. However there was no auditable evidence that care givers had been given specific restraint training for holding residents safely when personal restraint is required.</p> <p>The use of prn medication when a resident is exhibiting challenging behaviour is defined by St Andrew's as 'chemical restraint'. This is a misinterpretation of the definitions on the HDSS.</p>	<p>Ensure restraint procedures undertaken meet the intent and requirement of the Health and Disability Standards.</p> <p>90 days</p>

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	CI	<p>The orientation/induction programme is under regular review and improvements are monitored, reviewed and evaluated by the HR department with input from staff being fully documented. Having fully attained the criterion the service can clearly demonstrate a review process of review and evaluation of the orientation/induction programme where, based on the findings of the evaluation improvements to the programme have been put in place. In the staff files reviewed all staff received an orientation/induction programme that covered the essential components of the service provided related to the role they undertake with set competencies completed. These competencies are repeated annually. The need to keep competencies up to date is monitored and if a staff member does not complete within required timeframes they are notified and must attend the next available training</p>	<p>The orientation/induction programme has a generic section and a section which is streamlined to each service so that specific aspects required for that service is fully covered. Newly employed clinical staff have a ten day orientation/induction and are never counted as a staffing number for rostering until this time is completed. There are documented processes to show how each aspect of orientation is reviewed and evaluated. This includes feedback from new staff to ensure all their needs are met prior to being counted as a working number in the area they are employed.</p>

		<p>session. This is confirmed electronically and during staff files reviewed.</p> <p>Upon employment, referees are checked and job descriptions clearly describe staff responsibilities and accountabilities. Staff annual appraisals are up to date.</p> <p>Staff undertake training and education related to their appointed roles. There are compulsory education sessions which all staff must attend and these are closely monitored and reported against by staff line managers. There are systems in place so the service can assist staff to maintain all educational requirements.</p> <p>All staff interviewed stated that the orientation/induction programme is very comprehensive and allows them to understand and perform the role they are employed for in a safe and meaningful manner. Resident and family/whanau interviews confirm staff perform their roles to ensure needs are met.</p>	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>St Andrews has a system in place to identify, plan, facilitate and record ongoing education for all staff. The education calendar is available to all staff and education is advertised on staff information boards. Having fully attained the criterion the service can clearly demonstrate a review process undertaken for all education put in place. There is a dedicated staff member who oversees educational content and the frequency on-site education is delivered to ensure all staff have an opportunity to attend. Education sessions which are deemed as compulsory by the organisation are offered at a frequency to enable staff from all shifts to attend. Attendance numbers are very good and staff are paid to attend onsite</p>	<p>All education is reviewed and evaluated using a feedback form. The feedback given by staff related to education is used to make ongoing improvement to the education programme offered on-site. Off-site education feedback is relayed to the appropriate provider. There is auditable evidence that where feedback has been given which is negative a review and follow up is undertaken so that improvements can be made to the programme offered. All staff are supported and encouraged to undertake education related to their role. The organisation actively seeks out education that allows staff to hold a recognised qualification that can be use throughout New Zealand.</p>

		<p>education. Staff work in the dementia care hold specific qualifications.</p> <p>Staff interviewed confirmed that the standard and frequency of education offered allows them to maintain a high standard of service delivery. This is confirmed during resident and family/whanau interviews. One staff member who worked as a contractor and is now employed by St Andrews relayed information about now being able to undertake their role in a far more meaningful manner owing to the education offered and the support given by the HR team.</p> <p>All staff have intranet access and can locate information to assist them with ongoing education.</p> <p>The HR manager is very active in the pursuit of educational standards being available for staff who work in aged care and is working with the industrial training organisation (ITO) in the development of dementia care and the new level 4 senior support workers content for education.</p>	
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End of the report.