

Mercy Assisi Home & Hospital Hamilton Limited - Atawhai Mercy Assisi Home & Hospital

Introduction

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

The audit has been conducted by 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:	Mercy Assisi Home & Hospital Hamilton Limited
Premises audited:	Atawhai Mercy Assisi Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 March 2016 End date: 18 March 2016
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:	82

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

Atawhai Mercy Assisi Home and Hospital (Hamilton) Ltd is part of Mercy Healthcare Ltd. The Sisters of Mercy provide pastoral care consistent with the Mercy values which provides a strong culture promoting quality of life for each resident. Atawhai Mercy Assisi provides rest home and hospital level of care for up to 86 residents, with 82 beds occupied on the first day of audit. Since the previous surveillance, the service has increased beds that can be used for either rest home or hospital level care (swing beds) from the five approved beds to twelve. Six ‘swing beds’ (hospital or rest home level care) were occupied.

There have been major changes to the senior management team and a new executive manager and clinical manager appointed since the previous audit. A well-established quality and risk management system has been maintained over a number of years. The organisation continues to provide a high standard of care to its residents. Housekeeping services are now managed in-house. Minor refurbishment has continued, but there are no major changes to the environment.

This certification audit against the Health and Disability Services Standards (NZS 8134:2008) included review of documents and residents' files, interviews with staff, residents and family members and observation of the environment. Four areas requiring improvement have been identified at this Health and Disability Services Standard certification audit. Three relate to the quality and risk management system for document control, monitoring of follow up action in the internal audit programme and coordination of identified risks. A fourth area relates to identification and management of hazardous substances.

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 were observed undertaking day to day interactions with residents in a manner which respects residents' rights. Interviews with residents and family/whānau members confirmed that their rights are met during service delivery. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The staff interviewed were able to verbalise their knowledge and understanding of residents' rights.

Written consent to receive services is obtained from the residents or their appointed enduring power of attorney (EPOA) as appropriate. Information on informed consent is provided in the residents' admission pack and is fully explained as part of the admission process to reflect policy requirements. This is confirmed in documentation sighted and during interviews.

Evidence-based practice was observed, promoting and encouraging good practice. Resident and family/whānau member interviews confirmed that visitors are welcomed and that communication is open and honest. Family/whānau are kept informed if staff have any concerns or if there is a change in their relative's condition. Open disclosure is embedded in practice and recorded in residents' file when this is necessary.

The complaints management system is consistently implemented by the executive manager. Records are maintained to demonstrate compliance with the Code.

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.
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Atawhai Mercy Assisi Home and Hospital (Atawhai Mercy Assisi) has a strategic plan to 2025 and business plans, a quality framework including key performance indicators, and a comprehensive suite of policies to guide the organisation. Support from the Board of Directors of Mercy Healthcare is ongoing, with day to day care based on the values of the organisation. Since the previous surveillance audit, a new executive manager and clinical manager have been appointed to provide strong nursing leadership.

A well-established quality and risk management programme is fully embedded in all aspects of the organisation. Staff are engaged in quality improvement through the monthly 'opportunities for improvement' meetings. This meeting is the primary focus for quality activities and reporting. It allows staff to discuss issues affecting service quality. Key performance indicators including clinical indicators, health and safety and restraint minimisation, are documented and reported at these meetings. A thorough adverse event reporting system is used to capture a range of incidents, accidents, complaints and near miss events. These are also reported and discussed at the 'opportunities for improvement' meeting. A framework for internal auditing is focused in August each year and has been maintained. Improvement plans are developed and/or corrective action taken to address service shortfalls; however improvement is required where there are deficiencies from internal audits. Risks are identified, but greater integration between quality improvement, risk management and strategic planning and review of risk is required. Documented policies guide practice and organisational activities; however the system for archiving these documents requires improvement.

The organisation implements good practice human resources management processes. Staff receive a comprehensive orientation and ongoing training which meets the requirements of the Age Related Residential Care (ARRC) contract and essential components of the service. A largely manual system is used to identify, plan, facilitate and record ongoing staff training.

Staffing levels and skill mix are appropriate to the type of service, layout of the building and increase in the number of swing beds.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Details of entry criteria to Atawhai Mercy Assisi are available in written material in the welcome pack and electronically via Eldernet. Referring agencies are aware of the level of services offered at Atawhai Mercy Assisi. The admissions coordinator confirmed that if entry to the service was to be declined, a record would be maintained and the potential resident and their family/whānau would be referred to a more appropriate service.

Residents receive timely, competent, and appropriate services in order to meet their assessed need. The processes for assessment, planning, provision, evaluation, review and exit are provided within required time frames to meet contractual requirements. All residents had an up to date interRAI assessment with additional paper based assessments used as appropriate. The service uses a multidisciplinary approach to the identification of residents' needs in a manner that reflects coordinated care to promote continuity in service delivery.

The care plans reviewed described the required support and interventions consistent with residents' assessed needs. Care plans are evaluated at least six monthly, or sooner if there is a change in the resident's needs. Evaluation of care is documented. Where progress is different from expected, the service responds by initiating changes to the care plan and/or the introduction of short term care plans.

Support for residents to access or be referred to other health and/or disability service providers is appropriately facilitated to meet their needs. The alert process in place related to transition, discharge or transfer identifies known risks to ensure these are managed safely.

An activities programme is managed and implemented by providing a variety of group and individual activities to meet the interests of residents. Medicine systems implemented reflect safe medicine management processes. Residents and family/whānau confirmed the delivery of services meets their needs and wants.

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.

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

The facility has a current building warrant of fitness. A maintenance programme is used to ensure the building; plant and equipment are maintained regularly throughout the year. All equipment sighted was certificated as required, including fire equipment. The evacuation plan is well understood and practiced regularly by staff.

The residents' bedrooms and communal areas are spacious and well-lit with natural light and ventilation. Toilet and bathroom facilities allow for accessibility as do the hallways, ramps and outdoor paths. Residents express satisfaction and a feeling of safety with their environment.

Laundry and housekeeping staff demonstrated safe work practices in line with the required management of waste, and infection prevention policies. The use of personal protective equipment was evident in practice. A chemical register is available however the hazardous properties of the chemicals have not been identified as required for hazardous substance management.

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.

Atawhai Mercy Assisi demonstrates that the use of restraint is minimised, with a reduction in use over time. Enabler use is voluntary and the least restrictive option to meet the needs of the resident with the intent of maintaining safety and independence. At the time of audit there is one resident with an approved restraint and four residents using an enabler.

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.

A robust infection control programme is resourced to include external benchmarking of surveillance data which indicates the facility is in the lower percentile compared with similar facilities. Infection prevention activity is evident in the actions of care giving and service staff and potential outbreak identification is well understood, which has ensured the facility has not had an outbreak for over three years. The infection control nurse has dedicated office time and space to perform the responsibilities in line with best practice.

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	48	0	2	0	0	0
Criteria	0	97	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>Policies and procedures are implemented by staff to ensure residents' rights are met. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed in English and Māori throughout the facility.</p> <p>Staff files evidenced regular education is presented in relation to the Code. This was last presented in November 2015 during a staff education day. It is also discussed during orientation/induction and as part of the aged care specific education undertaken by health care assistants. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed delivering services in a respectful manner.</p> <p>Resident and family/whānau interviews confirmed service delivery is undertaken in a manner that meets all aspects of the Code.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	<p>Policy covers written and oral informed consent and directs staff to ensure informed consent is undertaken as part of everyday practice.</p> <p>The residents' files reviewed had signed informed consent. It is suggested</p>

informed choices and give informed consent.		<p>that this process could be more streamlined into one form. Currently separate consent is gained for physiotherapy and medication reviews. Residents and family/whānau confirmed all parts of the admission agreement are discussed prior to signing and explanations of the informed consent processes are given. Residents reported that they are not made to do anything they do not want to do.</p> <p>As observed residents are informed of what staff intend to do and staff respected the resident's right to refuse. Staff acknowledged the resident's right to make choices based on information presented to them. Staff acknowledge the resident's right to withdraw consent or refuse treatment at any time. Residents who have an advance directive have them activated by the service where they are valid. For residents who are unable to make an informed decision regarding an advanced directive related to resuscitation it is clearly shown that the GP discusses this with the nominated EPOA.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Documentation, including policies and procedures identify how the service recognises the resident and family/whānau right to advocacy services. The family/whānau members interviewed reported that they were provided with information regarding access to advocacy services and were also encouraged to involve themselves as advocates. A brochure for the Nationwide Health and Disability Advocacy Service is enclosed in the resident's information pack and is available at the entrances to the facility. One resident file contained information showing that they had chosen to have an independent advocacy service acting as their next of kin. The service respects and supports residents' right to make choices.</p> <p>Staff education in relation to rights and advocacy services is conducted as part of the in-service education programme. During interview staff confirmed their knowledge and understanding of how to contact advocacy services as required. Senior staff understand their responsibility to assist family/whānau and residents to gain an enduring power of attorney when required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau</p>	FA	<p>There are no set visiting hours and family/whānau are encouraged to visit at any time. The family/whānau report there are no restrictions to visiting hours. Residents were supported and encouraged to access community services with visitors or as part of the planned activities programme. The</p>

and their community.		volunteers who assist with many activities are from the local community area.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The facility has a complaints process which meets the requirements of the Code of Health and Disability Services Consumers' Rights. Few complaints are received and recorded in the complaints register. The executive manager states a proactive approach and open door policy means that concerns are readily addressed on a day-to-day basis. Complaints forms are accessible at reception.</p> <p>Where a formal complaint is raised, timeframes for acknowledgements, actions and conclusions are met. There are no known Health and Disability Commissioner complaints under investigation. Receipt of complaints is documented in the quality meeting (OFI – Opportunity for Improvement). Since June 2015, three complaints have been received actioned and closed.</p>
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Family/whānau and residents interviewed stated that the Code was explained to them and a copy of the Code is given in hard copy as part of the admission process. Nationwide Health and Disability Services Advocacy information is available at the facility and included in the welcome pack given upon admission.
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	<p>Policy is implemented by staff to ensure residents are treated with respect and dignity and that residents are not subjected to discrimination, coercion, harassment, sexual, financial, or other exploitation or abuse. Staff interviewed verbalised the actions they take as part of everyday practice to ensure residents are treated with respect and privacy whilst encouraging independence. This is supported by resident and family/whānau members interviewed and by observation on the day of audit. All resident and family/whānau interviewed during the audit were positive and a high level of satisfaction with the manner in which services are provided was reported. Residents confirmed all their needs, wants and likes are met.</p> <p>Privacy is maintained as all bedrooms are single occupancy. Residents' values, beliefs, religious and cultural needs are met by the service. This is identified in the care planning sighted and confirmed during staff and family/whānau interviews. One resident stated "I am treated very well</p>

		although I am not catholic. I really enjoy the mid-week interdenominational church service".
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	<p>Documented procedures and Māori advisors including Māori staff members are available to support non-Māori service providers to ensure Māori residents do not experience barriers. Care guidelines for Māori residents are available for staff, although there are no residents currently in the facility who identify as Māori.</p> <p>The Māori Health Plan describes the way in which the organisation endeavours to identify and provide the specific cultural needs of Māori and a copy of the Treaty of Waitangi is displayed.</p> <p>The provision of a comfortable whānau room is an indication of the importance the facility places on the relationship with whānau in the care and support of residents. This bedsit room with ensuite toilet is available for whānau to stay onsite as required.</p>
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	<p>Family interviewed stated their choice of facility was based on the availability of onsite Christian pastoral care and they were very happy with the pastoral services provided. Church services are held regularly throughout the week and residents and families are assisted to attend as desired.</p> <p>Pastoral care staff spoken with described their desire to provide safe cultural support to all residents of differing cultural and spiritual values and beliefs. Care planning recognises individual resident's cultural needs and staff described their desire to meet these.</p> <p>A cultural safety policy is available to guide staff in their practice and it includes reference to the education and training required.</p>
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff are made aware of professional boundaries upon employment in job descriptions and documented guidelines. This is confirmed during staff interviews. Residents and family/whānau interviewed did not express any concerns related to staff breaching any professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The nursing practice observed reflected current good practice for the level of care being offered. Policies and procedures which guide staff actions are linked to evidence-based practice. Services are delivered using a

		<p>multidisciplinary team approach with the resident having regular visits by the GP and/or the nurse practitioner, physiotherapy input, pastoral care on site, referrals being sent for community or DHB specialist service input as appropriate, such as speech language therapist, audiology, psychogeriatric services, the wound care nurse specialist and other health services are shown in residents' files reviewed.</p> <p>There are regular in-service education sessions and staff access external education that is focused on aged care and best practice. The family/whānau and residents interviewed were very satisfied with the care delivered.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Atawhai Mercy Assisi staff communicate effectively with residents and their families. This is acknowledged by resident interviews and is documented in resident files, where open disclosure has occurred. An open disclosure policy guides practice.</p> <p>Staff education covering the topic of good communication methods is offered regularly. Staff reported that they understand the process for accessing interpreter services. One resident who has English as a second language has key word sheets, one staff member speaks the same language and family/whānau assist as required. Staff confirmed there are no issues with communicating with the resident. Management confirm that the service would implement their interpreter policy if required to ensure residents can fully understand care options or as required.</p> <p>The family/whānau members interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in each resident's file and the service has just recently implemented a family communication sheet which was sighted in one of the eleven files reviewed. Accident/incident forms also identify that family/whānau are kept well informed.</p> <p>Staff report that information is shared during handover, at staff meetings and during education sessions. The GP reports there is good communication between all health care providers. This is supported by the pharmacist.</p>
Standard 1.2.1: Governance	FA	Atawhai Mercy Assisi is a well-established aged care service which has

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>operated from its current site on the outskirts of Hamilton. The Sisters of Mercy have operated the home since 1993, as part of the wider Mercy Health Care Ltd Group. The organisational structure is outlined in a document which shows the day-to-day operations are the responsibility of the executive manager and her team. She is accountable to the Chief Executive Officer who in turn reports to the Board of Directors of Mercy Healthcare Ltd. The Board in turn is linked to Mercy Ministries (Tiaki Manatu), which oversees the work of the Sisters, including at Atawhai Mercy Assisi.</p> <p>The organisation's purpose values and the scope of service are outlined in the strategic and business plan. Values reflect the philosophy of care of the Sisters of Mercy in New Zealand as outlined in their healthcare philosophy statement. Each year, the mission team identify one value for the year and integrate this into all activities including staff education and support. The wider Mercy Healthcare Group strategic plan outlines the organisation's directions through to 2025, including for aged residential care services. The organisation prides itself on being strongly values based, with this also confirmed at an interview with the CEO of Mercy Healthcare Ltd, who reports to the board.</p> <p>A new executive manager was appointed in June 2015 following the retirement of the long-standing CEO. She is suitably qualified, is experienced in aged care services both in New Zealand and overseas. She has the authority, accountability and responsibility for the day-to-day provision of services as outlined in the position description sighted. She is a registered nurse, holding a current practising certificate, and has attended relevant management updates including an update on the Health and Safety at Work Act 2015. A change of structure from two nurse managers for the rest home and hospital to one new dedicated clinical manager has recently been implemented with an appointment recently made to the role to re-establish staffing stability.</p> <p>The service is funded for rest home, hospital and respite care and end of life contracts. There are no residents receiving under 65 years or individual funding. Eighty-two beds were occupied on the first day of audit, with six of these being hospital level care residents located in the Rest Home area in a designated "swing beds". Fifty two residents are assessed as requiring hospital level care.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The appointment of a new clinical manager from February 2016 is seen as a positive step towards ensuring efficient and effective clinical management. The position description outlines her responsibilities for cover in the temporary absence of the executive manager. Alternative cover is also assigned in the absence of the clinical manager.</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>	PA Low	<p>The organisation has a documented and maintained quality and risk management system defined in policy, which identifies objectives and priorities. The Sisters of Mercy provide practical support for the organisation, with their 'care of the earth' philosophy and mission team activities. Organisational objectives are defined for service delivery, human resource management, and finances and infrastructure, with each area having its own performance indicators which are reported on by the executive manager. Examples of reports, interviews with the chief executive, executive manager, the management team and nine registered and enrolled nurses confirms the quality management system is known and understood, with a transparent process of meetings and staff engagement. The organisation is committed to continuous improvement at all levels which it demonstrates through its long-standing achievements in an Australasian accreditation programme.</p> <p>Policies and procedures have been developed and reviewed to reflect current practice and legislative requirements. A two or three yearly review period is applied to most documents. Document control is a defined and managed process, although changes are required in relation to the practice of overwriting documents.</p> <p>Elements which are key to the quality management system are consistently linked and reported on through the meeting structure. Minutes are maintained for the monthly opportunities for improvement (OFI) meeting. Terms of reference has been developed and the committee has wide representation from all levels of staff, with the potential to co-opt additional expertise for specific issues. All staff may also attend any of the meetings if they wish. This committee has the primary function of monitoring clinical and support systems and identify opportunities for improvement which impact positively on residents. With its strong clinical focus and data capture, it provides a useful forum for quality activities such as infection control, incidents, accidents and complaints, restraint</p>

	<p>minimisation and health and safety activities.</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated through the OFI meeting and service area displays. Key indicators are also reported quarterly to 'QPS Australia'. Reports for the last two quarters of 2015 were sighted and commentary of the results discussed. Comprehensive information is available for all key indicators, with trending and analysis evident. A process to measure achievement against the quality and risk management plan is implemented through the internal audits which are undertaken during a focused activity month in August. This is a fun, whole organisation approach to raising the profile of internal performance via audit. Called 'Action Albert', this is the period in which most routine audits are undertaken, however, greater focus on areas which are not achieving the desired results during the year is necessary to ensure problems are identified and rectified. Atawhai Mercy Assisi undertakes an annual relatives' survey. Results from 2015 have been summarised and analysed. Positive feedback is passed on directly to staff where individuals are named.</p> <p>A process for corrective action planning which addresses any required areas of improvement is developed and maintained. Examples noted include changes made following incidents, resident and family satisfaction surveys and complaints. A form is used to capture the information and any recommendations for implementation. These are taken to the OFI meeting, reviewed and signed off when completed. Follow-up of areas identified for improvement to ensure that actions taken are effective is not always completed for audit activities.</p> <p>The organisation has a system to identify actual and potential risks. A risk policy guides activities, with examples of risks being monitored, analysed, a severity rating applied and evaluated evident. Risks are grouped by type of risk, such as corporate, financial, employee and volunteer, patient care and other service areas, as described in the policy. Risk and hazard identification is included and integral to various committees including the opportunities for improvement committee (OFI). Although risks are formally reviewed on an annual basis, the system to ensure risks are reviewed at a frequency reflecting the severity of the risk or changes in the nature of the risk requires improvement.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>An accident/incident/hazards/near miss policy provides definitions and procedures to be followed. It includes a flowchart of actions and the reporting process for serious harm. Resident related medication incidents and pressure injuries are captured on separate forms.</p> <p>Examples of adverse events reviewed on ten adverse event reports forms demonstrated a variety of reporting including falls, staffing issues, medication errors and skin tears. All accidents/incidents are summarised on a monthly record and reported through to the OFI meeting. Staff interviewed understand the expectations for reporting adverse events. Data supporting monitoring of pressure injury events could not be located on the day of audit (see CAR 1.2.3.7). Meeting minutes include summary analysis of adverse events. Quality improvement actions are taken where shortfalls are identified. Data from adverse events and clinical indicators is benchmarked using QPS Australia services.</p> <p>Statutory and regulatory obligations in relation to essential notification reporting is understood. The senior management team are able to explain the requirements, including for Section 31 requirements related to pressure injuries. There are presently no residents with a grade three pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures to guide human resources management processes are in line with current good practice. Atawhai Mercy Assisi management report they seldom need to externally advertise for staff. The system to appoint new staff is followed, with prospective employees completing an application, being interviewed, police vetted and referee checked prior to appointment. Professional qualifications are validated where required, with evidence of these being sighted held on personnel records and a database. This includes contracted staff such as the physiotherapist, GP, nurse practitioner and registered nurse providing an ear clinic service. Position descriptions are in place for all roles.</p> <p>A structured orientation/induction programme has been developed and is implemented for all staff. Induction occurs on the first two days of employment, while orientation is completed during the first three months. This culminates in a three-month performance appraisal. There is an emphasis on the mission of the service, with staff made aware of the organisation, its history, structure and services. Each element of the</p>

		<p>programme is signed off on completion. Care staff complete an aged residential course (four unit standards) within the orientation period to meet the requirements of the ARRC contract. Health and safety, record keeping, infection control, manual handling and clinical care are all covered. This is evidenced in files reviewed for three staff employed for less than six months.</p> <p>Ten personnel files including individual education records were reviewed, alongside electronic records. The education programme reviewed confirmed there is a system to identify, plan, facilitate and record ongoing mandatory education undertaken by each staff group. Training is offered at mandatory core study days each year which staff are paid to attend. Health Education Trust through the Aged Care Education (ACE) training programme is the primary learning tool for care staff. This is offered by an in-house staff educator. The recording system for completed education remains largely manual and relies on staff reporting completion of external training such as the registered nurse requirement for Code of Conduct training. All nine registered nurses interviewed confirmed they had completed Code of Conduct training prior to July 2015.</p> <p>All staff are required to complete a core education each year. The content of the day includes aspects of quality, restraint minimisation, infection control, fire safety, health and safety, manual handling, residents' rights and a session on the organisation's mission focus for that year. Staff may apply for funding to attend external education and are required to provide feedback on this to their peers.</p>
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A Duty Rosters, Leave & Lieu Days policy guides staffing arrangements in the hospital and rest home areas. A significant change has been the introduction of an 'in-house' bureau, with newly appointed staff employed for minimum numbers of hours and able to flex up according to acuity and occupancy. This has been particularly valuable as the numbers of 'swing beds' has increased, enabling staff to respond quickly to increased resident numbers and need. A clear formula for increased staffing (two hours per additional hospital resident per morning and afternoon shift) is in place with use of a swing bed as evidenced in the rosters sighted for the current and previous week. Actual rosters for the previous two weeks indicated all shifts have been filled. The service has a policy on replacing staff to ensure clinical care is maintained – this includes use of an external bureau when required, although this is seldom now required. Staff

		<p>interviewed confirmed this strategy is reliably implemented.</p> <p>A registered nurse clinical manager is responsible for the rest home and hospital five days per week. The previous role of two nurse managers has been restructured into this new single role. The appointee has previously held a similar role. On call arrangements are shared with the senior registered nurses and executive manager.</p> <p>Diversional therapist cover has increased with the appointment of a trained therapist and increased diversional therapy assistants. There are now six staff providing 115 hours per week across the rest home and hospital and supported by a small group of volunteers. Currently, diversional therapy staff work Monday to Friday business hours and three hours on Saturday morning, although this has varied over time.</p> <p>The rosters reviewed confirmed a registered nurse is rostered on every shift in the hospital and a registered nurse on morning and afternoon shift in the rest home. Care staff hours vary from 4 to 8 hours with overlapping and staggered starts to cover high demand periods.</p> <p>Cleaning and kitchen staff are now employed by Atawhai Mercy Assisi rather than being contracted. There is adequate staffing cover by allied health staff with a contracted physiotherapist and employed physiotherapy assistant. A contracted general practitioner and nurse practitioner provide services to the majority of residents. The Sisters of Mercy are on site to provide pastoral care.</p>
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	<p>All residents have two core files; an integrated clinical record and a financial and management record. There is a Residents Record policy with flow chart which guides staff in record management. Residents' National Health Index numbers are used on their clinical files to ensure unique identification of each resident.</p> <p>The paper based integrated health record is held onsite for each resident which is documented in by all members of the multidisciplinary team. Relevant information is entered in a timely fashion by visiting health professionals when they visit a resident and by staff at the end or during their shifts.</p> <p>Residents' files were observed as being kept in lockable cabinets in locked offices. Clinical records are in the respective hospital or rest home</p>

		<p>nurses' office and financial records are in the financial administrator's office.</p> <p>An archiving system has been implemented and a record of both past and present residents is kept.</p> <p>Staff describe a full awareness of the requirements of relevant legislation in maintaining a confidential secure record management system.</p>
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	<p>The service implements policy related to service enquires and admission. There is an information package for potential residents which contain relevant information about the service and resident rights. The service has a dedicated admissions coordinator.</p> <p>Before a resident can be accepted into the service they must have an approved assessment for either rest home care or hospital level care. The entry criteria, assessment and entry process is clearly documented and communicated to the potential resident and family/whānau. The service reports their bed status daily and this can be viewed on the internet.</p> <p>Referrals are usually through the local Needs Assessment and Service Coordination (NASC) assessment team who are aware of the level of care available at this facility.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	<p>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms and 'yellow envelop system' approved by the DHB.</p> <p>Known risks are identified to the place of transfer in order to manage the resident safely. Expressed concerns of the resident and family/whānau are clearly documented including advanced directives and EPOA documentation. This is confirmed during residents' file reviews.</p>
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	<p>Policies and procedures describing safe medication management are implemented by the service. This covers the storage, administration and recording of medicines. There is policy in place which describes the process to follow for residents who are deemed competent to self-administer medicines. At the time of audit there are two residents who self-medicate part of their medication. During interview they verbalised their knowledge and understanding of their medications and the</p>

		<p>processes undertaken by staff to ensure they remain safe.</p> <p>With the exception of liquid medicines and stock medications, such as antibiotics, medicines are supplied by the pharmacy in a pre-packed robotics administration system for individual residents. There is a robust checking system in place which is undertaken by the RNs when medications are delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. The pharmacist confirmed that a full medication reconciliation occurs prior to each resident's annual multidisciplinary review. This is well documented. The pharmacy also has an alert system in place and the GP is informed of any contraindications of medications prescribed.</p> <p>Only RNs and ENs (enrolled nurses) administer medications and they have annual competency reviews. Safe medicine administration was observed at the time of audit.</p> <p>The medicines, controlled drugs and medicine trolley were securely stored. The management of the controlled drugs meets legislation and best practice guidelines. Two staff sign the controlled drug register when medication is given and a physical check is undertaken weekly. The medication charts are handwritten and this was discussed with senior management, the GP and the pharmacist. Evidence was provided that the organisation identifies this as a risk and the process for the introduction of computer generated medication charts is underway.</p> <p>All the medication files sampled had prescriptions that complied with legislation and aged care best practice guidelines. The GP and/or the nurse practitioner have conducted medication reviews for all residents within the last three months.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	<p>Each resident's dietary needs are assessed using the interRAI tool, and then nutritional requirements are incorporated into their care plan. The food services manager is informed of any specific resident's dietary needs on admission and following any change in need, for example weight loss.</p> <p>The menu is overseen by an external registered Dietician who stated when interviewed that the facility's recent menu review required only minor changes and that the menu was of above average quality.</p> <p>Pureed, soft and normal diets were observed in preparation and serving.</p>

		<p>Fortified drinks were available and stored correctly. Fluids in various forms to promote hydration are available to residents throughout the day including ice blocks in the warmer weather. A system to ensure modified and special diets are served to the right resident is understood by the staff using it and was used correctly when observed.</p> <p>The food services manager orders online, and checks orders against the delivery. The kitchen is run by the food services manager following Hazard Analysis Critical Control Point principles. Food preparation, storage, and transportation was described by staff and observed as following food safety guidelines. Fridge and freezer temperatures are monitored and were observed as being within correct ranges. A newly introduced system of dating food on arrival and again once opened or defrosted with expiry dates, ensures the safety of food provided to residents. Disposal methods employed ensure the timely removal of food scraps.</p> <p>Residents and family members expressed their satisfaction with the food and fluids available and commented that the staff and food services manager are always happy to respond to particular requests.</p>
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	<p>There is a process in place to record any request for service that is declined. If entry to the service was to be declined, the referrer, potential resident and where appropriate their family/whānau would be informed of the reason for this and of other options or alternative services. The admission coordinator confirmed potential residents who have had an appropriate needs assessment are accepted to the service if a bed is available.</p> <p>The admission agreement contained information on the termination of the agreement and if the service can no longer provide a safe level of care to meet the needs of the resident they would be reassessed for the appropriate level of care. One resident's file reviewed contained a recent needs assessment for a change of care level from rest home to hospital level care. The family/whānau member spoken to stated they were kept fully informed of this process and that they were more than happy with the service provided at both rest home and hospital level of care.</p>
Standard 1.3.4: Assessment	FA	The service uses interRAI assessments. All the residents' file reviews undertaken had current up to date interRAI assessments identified the

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>residents' needs and goals. Any specific areas are clearly flagged to identify that additional interventions will be required to manage risk. Additional paper tools are used for some issues such as pain, depression scale and falls. The physiotherapy and diversional therapy assessment information is included in resident care planning information. Assessments cover physical, spiritual, cultural and psycho-social needs of the residents. Initial assessments commence upon admission and are updated at least six monthly or if there is any change to the resident's condition. The goals set are resident focused. Short term issues which arise have completed paper assessments to inform the care plans in place for example wound care plans are informed by a paper based assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The service has fully implemented the use of the interRAI assessment and uses their own care plan format. All the care plans reviewed evidenced individualised care plans that reflected the resident's needs. The care plans reviewed demonstrated service integration. The resident's files have one main folder that contains the medical information, nursing assessment, care plan, routine observations, activities, therapies, and correspondence such as specialist consultations. Staff interviewed confirmed they use the care planning information to undertake day to day cares and that they are written in a manner that is easy to follow. The interventions shown on care plans (both long and short term), accurately reflect the assessment findings.</p> <p>The residents and family/whānau interviewed reported that the clinical staff have excellent knowledge and care skills. They acknowledge and verbalised their input into care planning and they gave examples where their involvement has changed some aspects of the care planning process upon request. (This was evident in both files reviewed in detail).</p> <p>The GP interviewed expressed satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The care plans reviewed were individualised to show interventions put in place to contribute to meeting residents' goals. Information sighted on care plans is congruent with assessment findings. The care staff interviewed reported they were informed of any care plan changes at hand over and in the information book. Staff have relevant in-service education as required specific to any new interventions such as percutaneous endoscopic gastrostomy (PEG) feeding.</p>

		Residents and family/whānau interviewed reported a very high level of satisfaction with the services they receive.
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	<p>The service has two diversional therapists and four activities assistants. Activities assessments sighted in residents' files identify residents' likes, skills and abilities. The diversional therapist interviewed confirmed this information is used when developing individualised and group activity plans. The diversional therapy programme is focused on giving the residents back or assisting them to remain as independent as possible. The service increased the numbers of diversional therapy staff owing to the introduction of the 'Spark of Life' programme. Both diversional therapists have completed training in this area and the activities assistants are registered to undertake the training.</p> <p>There are planned activities that covered physical, social, recreational and emotional needs of the residents. Community involvement is encouraged and the service is building a volunteer base. Feedback received from the residents and family/whānau is taken into account when planning activities.</p> <p>All residents interviewed were aware and involved in the activities programme to whatever degree they choose. This is confirmed in the attendance sheets sighted.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Evaluations are documented at least every six months. The degree of achievement or response to the interventions put in place are shown and measure if the resident has achieved their goals or are still working towards them. The amount of information shown on the evaluation column of care plans varies between the hospital and rest home area and it is suggested this be unified. The evaluations sighted in the hospital files contain more explicit detail.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan and/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/whānau interviewed reported very high satisfaction with the care provided at the service.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents may use the GP of their choice. However, the service has a contracted GP group and a nurse practitioner who manage all current residents. Referrals to other health providers is supported by the organisation and facilitated by the GP, the nurse practitioner and RNs. This is confirmed in resident file reviews and during resident and family/whānau interviews.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	PA Low	<p>Staff were observed following the facility's documented processes to protect residents, visitors and themselves from harm as a result of handling hazardous or infectious substances.</p> <p>Correct storage and disposal of waste was observed and staff described their actions in line with the facility's documented processes.</p> <p>Protective equipment including gloves, aprons, and goggles are supplied and staff described how and when they are used for protection.</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>The current facility Building warrant of fitness was sighted. There is a planned maintenance programme which ensures all plant and equipment is well maintained, fit for purpose and compliant with relevant legislation.</p> <p>The ten hoists have had a recent annual check and all other equipment sighted throughout the facility had current certificates as required.</p> <p>The facility is all on one level and makes use of handrails, wide halls, and ramp access for the ease of resident movement in and around the property. A recent refurbishment in the hospital wing enables ease of movement for all wheeled equipment on linoleum flooring.</p> <p>The facility is clean and tidy and staff described that any spillage is 'everyone's job' to clean up immediately to decrease any risk to residents, visitors or staff.</p> <p>Residents have several readily accessible exits to many external seating areas some of which have recently had shading added. Residents and visitors can walk on flat paths through the large gardens. A pleasant contemplative space with seat and an outdoor aviary are also available in the garden. Residents and family members spoken to say they feel safe inside and outside the facility.</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>Residents are assured of privacy in the accessible toilets, showers and bathrooms they use. Hospital residents have ensuite bathrooms and rest home residents share facilities that are close to their rooms. Residents and family members interviewed stated their satisfaction with these.</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>Residents with and without mobility aids such as wheelchairs and walkers were observed moving about the facility and around their own rooms with ease. Residents were able to have their own possessions in their rooms due to the amount of space available to them, which provides a homely feel to the facility.</p> <p>Both residents and the families interviewed stated their satisfaction with the spaces available.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Large light airy communal rooms including the chapel, dining rooms, lounges, sun rooms and kitchenettes, are available to residents and their visitors. Residents and visitors were observed enjoying these spaces and when interviewed expressed their satisfaction with the shared areas and the variety of these. The planned improvements described by several managers are expected to enhance the residents' experience and has involved consultation with residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility was seen to be clean and tidy. Both the laundry and cleaning services are run by in-house staff.</p> <p>Documented policies provide laundry and housekeeping staff with guidance including management of spills and infection outbreak management.</p> <p>An external cleaning chemicals contractor provides a monthly monitoring service of the laundry chemicals system and changes are made to the chemical mix as required.</p> <p>A recent review of the cleaning contract has resulted in service improvements. New cleaning methods have been introduced and by bringing this service back in-house, cleaning service hours have been extended.</p> <p>The laundry chemicals are supplied via a pump system which is monitored</p>

		<p>and managed by the external contractor within a locked cabinet which staff do not have access to.</p> <p>Safe storage areas for cleaning equipment and chemicals were sighted.</p>
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	<p>Staff receive information at orientation and throughout the year on all aspects of emergency, fire and security situations. Staff interviewed had attended training and described their responsibilities as documented in the facility's procedures. Wardens, who are senior nursing staff, are allocated to each shift and rotated as part of the roster.</p> <p>There is an approved evacuation plan and reports from regular fire evacuations were sighted. When interviewed staff described their responsibilities in the event of an evacuation and indicated a clear awareness of the wardens' roles.</p> <p>The facility has backup systems in case of utility failure which includes generators for power, four 40,000 litre water tanks and gas bottles for cooking on an outside BBQ. The water tanks are connected to each other and have a tap for easy access if required.</p> <p>There is a call bell system in all resident areas throughout the facility which was observed to be working well.</p> <p>Gates have been installed for vehicular access which open slowly when approached on entry and require manual activating to exit.</p> <p>There are security procedures for locking up at night, which nursing staff described as per the policy. An external contracted service does security checks at night. They report to the senior registered nurse and document their visit including any issues, in the security book kept at the hospital reception. Lighting and surveillance camera signage is in place as deterrents. Keys are stored securely in a key pad locked cupboard.</p>
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	<p>Areas are ventilated and heated with air conditioning units. Additional safe portable heaters are provided for those residents and staff who request this.</p> <p>Doors and windows open to the air, externally and into internal courtyards. There is one courtyard, specifically for residents and another specifically for staff use.</p>

		All resident rooms and communal areas have at least one opening window and these are of generous proportions. Residents, family members and staff all indicated their satisfaction with this.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	<p>There is an experienced enrolled nurse who is the delegated infection control nurse, responsible for overseeing infection prevention and control who reports to the executive manager and the opportunity for improvement group. The executive manager described the responsibility for reporting infection control issues through to the board. There are clear lines of accountability documented in the full suite of infection prevention and control policies and staff interviewed described that everyone has responsibilities for infection prevention and control. The specific responsibilities of the infection control role are documented in the role description.</p> <p>The infection control programme has been documented and incorporated into the quality and risk plan as part of an annual review process and includes relevant activities such as vaccination, audit, education, monitoring, surveillance, and review of outbreaks.</p> <p>Policy guides staff practice in regards to suspected outbreaks to prevent residents, family and staff exposing others to their infection.</p> <p>Caregivers and registered nurses interviewed described their outbreak procedures and precautions taken which mirrored best practice and what is required in the facility's policies. Staff were proud to declare they have not had any infectious disease outbreaks for over three years. Outbreak trolleys and policies were sighted.</p> <p>The infection control nurse gives education sessions at caregivers and nurses meetings specific to their work activity regarding outcomes and infection prevention practices, for activities such as linen handling and hygiene cares.</p>
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 nurse has dedicated time, an office and a computer readily available onsite. As a member and past president of the Waikato Long Term Care Facilities Infection Control group, the infection control nurse has access to Waikato District Health Board staff infection control expertise. Training opportunities are available to the infection control nurse through the enrolled nurse professional network and externally

		<p>provided infection prevention and control resource manual relevant to the New Zealand setting.</p> <p>The infection control nurse keeps abreast of sector changes online and was able to describe recent changes and new knowledge in this area. The infection control nurse is supported by the onsite clinical manager and the opportunities for improvement group in this role.</p> <p>The needs of the organisation are met by the human, physical and information resources available and the infection control programme is run effectively.</p>
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	A full suite of relevant policies is available to staff throughout the facility, which reference certification and accreditation standards and incorporates surveillance, education, employee health and outbreak management, Hepatitis B and staff screening, standard and transmission based precautions, handwashing and alcohol rubs, personal protective equipment, blood and body fluid exposure, surveillance definitions, outbreak management and flow charts, notifiable disease, decontamination, sterilisation, disinfection and cleaning.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>Infection control education begins at orientation and continues to be offered throughout employment. Staff are initially provided with a pocket sized infection prevention and control staff policy handbook which includes information on each of the infection control policies including safe handling and disposal of waste. The infection control nurse is suitably qualified and maintains infection prevention knowledge through attendance at professional forums and online networking.</p> <p>Resident education is given individually on an ad hoc basis when an infection occurs, to prevent cross infection. Staff report they document this in the patient's notes as required at the time. Diversional therapy staff encourage residents to use the alcohol hand gel as a routine prior to all activities and the use of paper tissues rather than hankies. Family and visitors are notified by telephone or email of an outbreak and are encouraged to ring the residents rather than visiting to keep up contact. When they do visit visitors are encouraged to only visit their family member. The infection control nurse discusses infection prevention strategies with the resident and their family during the admission process.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The facility is enrolled in an external quality benchmarking programme and chooses indicators to monitor based on their resident population. These statistics are gathered and reported on quarterly, and in addition the infection control nurse reports monthly on infection control matters to the facility wide opportunity for improvement group and the executive manager.</p> <p>Results of the external quality benchmarking are tabled at all of the facility's staff and management meetings and are made available to residents and family members. The opportunities for improvement group review the recommendations and agree actions, which are documented. Recent results sighted are in the lower percentile.</p> <p>Nursing and caregiving staff are trained to identify a suspected outbreak and act accordingly to prevent an outbreak. These occurrences are reported to the infection control nurse who evaluates, notifies and reports to staff and managers concerned, to ensure an immediate appropriate response. This robust system was described by the nurses and caregivers interviewed in line with the documented policies.</p> <p>Typical infections reported include infections of the gastro intestinal tract, respiratory tract, urinary tract, skin, eyes, and multi-resistant organisms. Infections are trended and any unusual patterns are investigated by the infection control nurse. Specific resident's files are reviewed by the infection control nurse if a resident has had a multi-resistant organism or extended spectrum beta-lactamase infection.</p> <p>The surveillance data collected meets the requirements of the Health and Disability standard.</p> <p>Antimicrobial use is also trended by the infection control nurse and this information is provided to the facility's general practitioner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Enablers are used for safety purposes with four residents. These are lap belts in wheelchairs and a single bedrail to increase the feeling of safety when in bed. This voluntary use has been requested by the resident to aid their independence, with its use documented interRAI and the resident's care plan. Staff receive training on the use of both restraint and enablers as seen in the orientation programme and the core study day training content.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Approval processes for restraint is formalised and the responsibility of the Restraint Steering Group and reviewed monthly at the OFI meeting. A job description for the restraint coordinator defines responsibilities and has been updated for the new clinical manager who undertakes the role. The restraint policy outlines the approved restraints which are bedrails, a bed harness, chair harness and lap belt. Not all approved restraints are used. Locking of an external door is described as a short term emergency action in the restraint policy – there are no records of this ever being implemented.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Factors which influence the safe use of restraint are considered as part of the assessment process prior to the decision to implement restraint. De-escalation is part of the strategies which may be tried to minimise the use of restraint. Staff interviews and records confirmed that risks of implementing restraint are individually considered as part of the assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>There is clear guidance provided in a current restraint policy and procedure which guide safe restraint use. A Waikato District Health Board guidance document applicable to secondary and residential care is also referenced in the restraint folder. The restraint committee is a subcommittee of the OFI meeting. It considers the safe use of restraint, consent, product evaluation and monitoring of its use. Minutes confirmed the reporting which occurs at this committee. Each episode of restraint is documented in sufficient detail in the restraint folder and the resident care plan to provide an accurate account of the indication for use, intervention, duration and outcome. Files reviewed indicated that most residents are long term users, with one recently suspended due to a change in the resident's health status. The restraint folder functions as a restraint register.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The response to any new restraint initially occurs during the first 24 hours, and then it is reviewed again after 72 hours. Once it is seen as the safest option, it is incorporated into the interRAI assessment and long term care plan, as seen in three files sampled. There are examples of enablers in use which are evaluated as part of the care planning process.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The OFI meeting is the forum for the restraint steering group to review all restraint and enabler activity. Meeting minutes sighted from the monthly meeting demonstrate comprehensive monitoring and quality review of restraint is included. Over the past three years there has been an overall reduction in the use of restraint, with fewer residents restrained and for one device (chair harness) there has been a steady drop of recorded hours in restraint. This achieves the outcome of restraint minimisation.</p>
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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 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	Document control systems are established and detailed in policy. Many of the policies have been rolled over as they have fallen due, rather than fully reviewed, due to pressure and the absence of a clinical manager to assist. The document control policy focuses on format and authorisation and does not provide sufficient detail or include all aspects of document control and archiving requirements.	The document control system is defined in policy however lacks guidance in the management of document review and archiving of documents. Presently documents which are reviewed are electronically overwritten to create a new version and the previous version is not retained in the system.	Ensure the document control policy provides sufficient guidance for control and management of all documents and for archiving of obsolete documents. 180 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	‘Action Albert’ is the internal audit programme undertaken annually. The focus is on completion of quality audit requirements in a fun manner, with various staff invited to participate to complete individual audits. The most recent cycle completed in August	The audit programme (Action Albert) has no defined acceptable performance levels and when deficiencies have been identified; there is no evidence of more frequent monitoring or improvement activity. Not all data	Ensure the internal processes for audits are documented and audits include the required levels of performance for the area being audited. Less than optimal results are followed

		<p>2015 provide a percentage result against the previous year. In a number of examples, the results are noted to be down on previous years. No levels of acceptability for the audits are defined, to quantify when further action is needed. Where deficiencies have been identified, there is no evidence of more frequent monitoring or improvement activity. For example, care plan evaluation was rated 72% however no action plan was developed and the review period for re-audit remained at one year. A second example relates to a significant decrease in compliance for the preferred providers and contractors. Again, no evidence of follow-up is seen. The frequency of monitoring does not reflect the results obtained from the audit programme. In a further example, a key area of monitoring for pressure injuries is stated to occur six monthly, however no documented data could be located to confirm this has occurred.</p>	<p>is available.</p>	<p>up to ensure the remedial plan has been effective.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed,</p>	<p>PA Low</p>	<p>Risks are grouped according to types of risk such as corporate, financial, employee and volunteer, patient care and other service areas as defined in the policy. Risk and hazard identification is included and integral to various committees including the opportunities for improvement committee (OFI). However, there is no coordination of the risks which ensures that identification, risk rating and suitable review periods are</p>	<p>Although organisational risks are captured, there is a lack of integration between quality improvement, risk management and strategic planning. Risks are not consistently reviewed at a frequency relevant to the significance of the risk or any changes that have occurred.</p>	<p>Develop integrated systems and processes which addresses the range of organisational risks to ensure that these are adequately monitored, analysed, evaluated and reviewed according to the nature and severity of the risk</p>

<p>evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>included (eg, such as management of all identified risks via a central risk register). Reporting of risk is not seen as an explicit process except where this relates to health and safety. Risks are described in the policy as reviewed annually, but this is not seen as formally implemented at an operational or management level. Strategies to manage each existing risks are not reviewed nor updated where there a change in the status of the risk has been identified.</p>		180 days
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Low	<p>Processes are documented and followed where substances are recognised as being hazardous. There is a chemical register which is available to be provided to the Fire Service in the event of a fire callout. Safety data sheets, and personal protective equipment is available for some hazardous substances.</p> <p>Correct storage and disposal of waste was observed and staff described their actions in line with the facility's documented processes.</p>	<p>Chemicals are not adequately assessed for their hazardous properties therefore disposal of hazardous substances could potentially be inadequate.</p>	<p>Review the onsite hazardous substances and create an accurate hazardous substances register which incorporates all aspects of hazardous substances management.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.