

Kapiti Retirement Trust - Sevenoaks Lodge

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: Kapiti Retirement Trust

Premises audited: Sevenoaks Lodge

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: 13 April 2016 End date: 14 April 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: 57

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

The Kapiti Retirement Trust in Paraparaumu is certified to provide rest home, dementia and hospital level care for up to 52 permanent residents and seven respite care residents at Sevenoaks Lodge. The permanent residents are either hospital or dementia level care with respite care services being provided for both rest home and hospital level residents. On the day of this audit there were 57 residents.

This certification audit was conducted against the relevant 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, residents' and staff files, observations, and interviews with residents' families, management and staff. A doctor and a physiotherapist were also interviewed.

The Trust is managed by an experienced chief executive officer (CEO) supported by a group manager support services and a group manager resident wellbeing. A clinical manager also oversees the management of the care facility. All were present on the day of audit.

There were no areas identified as requiring improvement. Three areas of continuous improvement have been awarded relating to medication reconciliation on entry to respite care and quality initiatives implemented around falls, managing residents' safety and hazardous waste management. The two areas identified as requiring improvement at the previous audit have been addressed.

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.

Care provided to residents is in accordance with consumer rights legislation. Residents' values, beliefs, dignity and privacy are respected.

There are no residents who identify as Maori at the time of audit, however appropriate policies, procedures and community connections ensure culturally appropriate support can be provided.

Residents interviewed feel safe, there is no sign of harassment or discrimination, staff communicated effectively and residents are kept up to date with information. Residents, or their enduring power of attorney, sign a consent form on entry to the service with separate consents obtained for specific events.

The service informs residents and their families of how to access the Nationwide Health and Disability Advocacy Service and encourages residents to maintain connections with family, friends and their community and to access as many community opportunities as possible.

An effective complaints system is in place with all response timeframes clearly documented. Any issues raised in the past year were low level and all resolved satisfactorily.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The Kapiti Retirement Trust is managed by an experienced and well qualified CEO and a team of managers who oversee the day to day running of the facility at Sevenoaks Lodge. The CEO and her team are well supported by the trust board. Planning is detailed and is responsive to any changes required both at legislative and facility level.

A comprehensive quality and risk management system is in place with robust reporting. There is a quality improvement plan which includes an annual calendar of internal audit activity, including monitoring of the administration functions, human resources and staff training, health and safety, infection control, medication and restraint. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and subsequent corrective action planning, feeds into the quality improvement cycle to manage any further risk and ensure a continuous quality improvement occurs.

A sound recruitment and appointment system is in place and staffing levels meet and often exceed all the requirements. A comprehensive training programme is in place to maintain a high level of competence of all staff. Staff report high job satisfaction and enjoy the supportive environment they work in.

Residents' information is accurately recorded, and all information was securely stored and not accessible to the public. Service providers use up to date and relevant residents' records.

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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The organisation works closely with the Needs Assessment Co-ordination Service to ensure access to the service is efficient and relevant information is provided, whenever there is a vacancy.

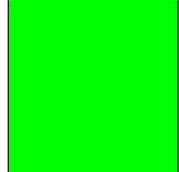
Residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has been purpose built and is very well maintained with a number of full time maintenance and grounds staff employed at the complex. The residents' rooms and the communal areas are spacious, very clean, airy and kept at a comfortable temperature for residents. There are adequate shower and toilet facilities. The building has a current building warrant of fitness.

Robust systems are implemented for the management of waste and hazardous substances by staff who have been trained in this area.

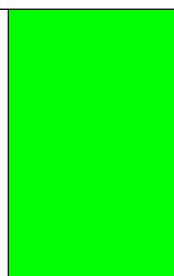
Emergency procedures are well documented for ease of use and available in a number of places around the facility. Regular fire drills are held and there is a sprinkler system installed in case of fire. Access to an emergency power source is in place. A security firm is contracted to monitor the facility each night.

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.
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The organisation has policies and procedures that meet all the requirements of the standard and these are followed for all enabler and restraints in use. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews is occurring. The use of enablers is for safety of residents in response to individual requests. These are all monitored and reviewed regularly.

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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The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined with the infection control nurses reporting directly to the group manager for resident wellbeing who reports to the trust manager

There is an infection prevention and control programme for which external advice and support was sought; this is reviewed annually. Two infection control nurses are responsible for this programme, including education and surveillance.

Infection prevention and control education is included in the staff orientation programme, annual core training and in topical sessions. Residents are supported with infection control information as appropriate.

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked externally. The results of surveillance are reported through all levels of the organisation, including governance.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Interviews with residents and family members of residents verified services provided complied with consumer rights legislation. Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Clinical staff were observed to explain procedures, seek verbal acknowledgement for a procedure to proceed, protect residents' privacy, and address residents by their preferred name.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	The informed consent policy describes all procedures to ensure the residents rights to be informed of all procedures undertaken. Documentation, observation and interviews evidence information is provided to make informed choices. Informed consent is understood and is included in the admission process. The resident, and where desired family/whanau, are informed of changes in the resident's condition and care needs, including medication changes. Residents' choices and decisions, including advance directives, are recorded and acted on where valid.

consent.		
<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>The service recognised and facilitated the rights of residents and their family/whānau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilised appropriate community resources, both internally and externally. Residents and their families are aware of their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whānau in the provision of care, and the activities programme actively supports community involvement.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints/concerns/issues policy and associated forms that meet the requirements of Right 10 of the Code. These are provided in the first instance to all new residents in the information pack. Forms are also available in a number of areas in the facility including outside the nurses stations and at reception. All complaints are recorded in the complaints register. These are reported on regularly to the management team. The complaints register was reviewed and all complaints are well documented with copies of all responses made. All meet the required timeframes as per the organisational policy. The two complaints received over the past twelve months were reviewed and both were resolved satisfactorily. The group manager who takes responsibility for all complaints confirmed any complaints are forwarded to her and are responded to in writing well within the required timeframes. Corrective actions are initiated as appropriate and form part of the quality improvement process.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Interviews, observations and documentation verified residents are informed of their rights. Information on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and the Nationwide Health and Disability Advocacy Service is displayed and accessible to residents.</p>

their rights.		Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission. Legal advice is able to be sought on the admission agreement or any aspect of the service. Information is provided on the facility's range of costs and services.
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	Policy identifies that procedures are in place to ensure residents are kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse. Residents receive services which treat them with respect and has regard for their dignity, privacy, sexuality, spirituality and independence. Staff demonstrated policy awareness and responsiveness to residents' needs.
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	Documentation is in place to guide staff practices to ensure residents' needs are met in a manner that respects and acknowledges their individual cultural, values and beliefs. Policy states that this is to be identified upon entry as part of a resident's care planning process. The organisation had a documented Maori Health Plan which identified their priorities related to culturally safe services. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (Partnership, Participation and Protection). Whanau relationships and involvement in care are recognised. The local marae, supports the needs of Maori residents and will assist if required. There were no residents who identified as Maori at the time of audit. Staff receive education in relation to cultural safety and the Treaty of Waitangi.
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	Policy identifies that residents receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values and beliefs. Evidence verified residents' received and are consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs.

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Policy indicates that residents are to be free from all forms of discrimination, coercion, harassment and exploitations. Orientation/induction processes inform staff on the Code. The Trust's house rules, policies and procedures provide clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries.</p> <p>Interviews verified staff understanding. Residents felt safe and received a high standard of support and assistance and reported there was no sign of harassment or discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice and high standards. Policies sighted are current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which are monitored and evaluated at organisational and facility level.</p> <p>The increased use of low dose cytotoxic medicines in aged care for the treatment of autoimmune, dermatological, neurological conditions and rheumatoid arthritis and the risks associated with these medicines, resulted in the service investigating the development of a policy to manage these medications. There was little information available in the aged care sector on how to deal with cytotoxic medicines and their waste. Most information is available for high dose cytotoxic medication. Cytotoxic medicines are known to have carcinogenic, mutagenic and tetragenic properties. After research and input from a wide range of experts, a safe and workable cytotoxic policy was developed to ensure staff are fully conversant with management. The policy makes reference to pregnant or breastfeeding woman, not administering low dose cytotoxic medication, hand hygiene and the use of gloves.</p> <p>Evidence verified a range of opportunities is provided to enable staff to provide services of a high standard. Staff speak highly of the support management provides in enabling them to seek appropriate opportunities to learn and to provide high care standards. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	<p>FA</p>	<p>Policy identified that interpreter services are available and offered to residents with English as a second language. The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided. Communication with relatives is documented in the residents' communication records and incident forms and verified an environment conducive to effective communication.</p>

effective communication.		
<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>	FA	<p>The Kapiti Retirement Trust is governed by a voluntary Board of Trustees who have a chief executive officer (CEO) who is supported by an experienced senior management team to manage the aged care facility. The trust has a five year strategic and business plan (2014-2019) which is reviewed annually by the board and the CEO. The vision and goals of the organisation are clearly documented in the plans. The current business plan details the planned goals and actions for the current year and the CEO completes monthly reports, which are informed by regular senior management reporting, for the board at their meetings. The CEO also meets more regularly on an informal basis with the board chair. This regular communication supports the “no surprises” policy adopted by the CEO and board. The minutes of the previous three months board meetings were reviewed and demonstrate comprehensive reporting and appropriate governance activity is occurring.</p> <p>The CEO has been in the role for seven years and has extensive previous experience in business management.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the CEO is absent, the other members of the of the senior management team are able to step up and carry out all the required duties. The board chair is also available on call as necessary. The clinical management is overseen by three clinically qualified managers who are all experienced in the sector and are able to take responsibility for any clinical issues that may arise during any absences.</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>	FA	<p>There is a detailed quality and risk management plan which is reviewed annually. The current plan is dated 2015-16. A range of quality indicators are monitored throughout the year. These include clinical indicators (assessments, falls, pressure injuries, skin wounds, restraint, infections, medication errors, incidents / accidents) as well as non-clinical indicators including complaints, security / emergency incidents, staff injuries, in-service training and attendance, staff appraisals, induction and orientation of new staff and occupancy rates. Regular reporting on all quality indicators is completed and analysed and these are collated for the management team to inform the quality cycle. Relevant corrective actions are developed and implemented as indicated. The quality process – ‘plan; do; check; act’ (PDCA) is the quality process used to address all issues that are identified as needing a response. These were reviewed and demonstrated a continuous process of quality improvement is occurring.</p>

		<p>The following committees meet regularly: restraint approval; registered nurses; the pressure injury group; health and safety; staff development and training; falls; infection prevention and control; health care assistants group and resident and family surveys are completed annually. Regular staff meetings are also held.</p> <p>A comprehensive internal audit programme is scheduled annually in advance. The results of these are also collated, reported to the management team and relevant corrective actions raised if needed.</p> <p>The risk register details all current and ongoing risks and these risks are reviewed continuously.</p> <p>All managers complete regular reporting to the management team to keep them well informed of all activity in their areas. Manager's reports were reviewed and these contained detailed and relevant reporting.</p> <p>Policies reviewed are comprehensive and current with regular reviews occurring. A document control system is in place. All staff are expected to read all new and revised policies to ensure they fully understand any changes and updates that are made.</p> <p>Staff interviewed all report they are involved in and kept well informed of all quality activity at the facility.</p> <p>Regular newsletters are produced for residents and families to ensure they are fully informed about any quality initiatives happening on site.</p> <p>A continuous improvement is awarded for the development of a process for managing risks for residents who may get lost while going out and about around the facility.</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>	<p>FA</p>	<p>Detailed policy and guidelines are developed for incident management and reporting. The incident reporting process is observed with an incident documented on the paper form then the Group Manager Resident Wellbeing reviews them and implements any necessary corrective actions. All incidents are recorded and analysed and reported to the monthly RN meeting. The form includes documentation of notification of family and medical professionals where relevant. A copy is also filed onto the resident's notes. All staff are responsible for reporting and responding to incidents and in interview they all confirmed they understand and follow the required processes.</p> <p>The register of all incidents and accidents was reviewed and all necessary recording had been completed as per the policy.</p> <p>The group manager confirmed there is regional public health/DHB approved equipment on site for all cases that require isolation and the process for notification to authorities is clearly understood.</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>A comprehensive set of policies for recruitment and training that meet all legislative requirements provide a sound basis and process for all staff recruitment and development activity. Staff files reviewed have all the required documentation including police checks, reference checks, job descriptions, individual employment contracts, CVs, orientation sheets and current performance appraisals. Also included are training records for all individuals. Competency checks are completed prior to any appointments. Professional qualifications are verified and filed. Other professionals who are independent of the facility also have relevant checks completed. All APCs are current and securely filed. New staff receive a comprehensive orientation programme and complete a workbook which is supervised and checked to ensure staff are ready and able to complete their duties as required. A significant number of care staff have completed NZQA certificates and all dementia staff have undertaken relevant units. A majority of all staff have current first aid certificates. The annual training programme that has been developed ensures all staff have relevant training opportunities that cover all requirements for aged care.</p> <p>A total of six registered staff are interRAI trained and pressure injury training has been completed by all care staff. Staff report they participate in as many of the training opportunities as possible.</p> <p>A new initiative developed by the staff development committee involves regular dissemination of health focussed education fact sheets which are placed on staff bathroom doors. This includes information on melanoma, tattoos, alcohol use, depression and hearing loss. This is proving very effective with positive feedback from staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The facility has staffing levels that reflect the needs of the residents. Clinical rosters are prepared monthly in advance. The current rosters sighted demonstrated the required skill and experience mix which reflected the organisation's staffing rationale policy. There is a pool of casual staff that are able to cover any absences and the use of agency staff is very low. At least one staff member on duty at all times has a current first aid certificate and there is 24 hour seven day a week (24/7) RN coverage. Staffing levels are adjusted when respite beds are in use.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	<p>FA</p>	<p>There was no personal or private resident information on public display during the audit. The residents name and date of birth and national health index (NHI) are used as the unique identifier on all resident information sighted. Clinical notes are current and integrated with GP and auxiliary staff notes. The files are kept secure and are only accessible to authorised people. On the day of admission all relevant information is entered into the residents file by the RN following an initial assessment and medical exam by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, national health index number (NHI), the name of the GP, authorised power of attorney, allergies, next of kin and</p>

when required.		<p>phone numbers are all recorded in each resident's record.</p> <p>Archived records were being held on site in a secure room. These are catalogued for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>When the need for service had been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Information about the service, includes full details of the services provided, its location and hours, how the service is accessed and identifies the process if a resident requires a change in the care provided.</p> <p>Files reviewed contained completed assessments. Signed admission agreements met contractual requirements.</p> <p>The services management of a potential risk identified in residents accessing the respite service has been identified as an area of continuous improvement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes.</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>	FA	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management is observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Controlled drugs are stored in separate locked cupboards. Controlled drugs are checked by two RNs for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart.</p>

		<p>There are no residents who self-administer medications at the time of audit; however should this be required appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the group manager for resident wellbeing and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are used and documentation is compliant with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietician's April 2015 documented assessment of the planned menu.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Kapiti Coast District Council has issued an A grade certificate of registration that expires June-2016</p> <p>The effectiveness of chemical use in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews and sighted satisfaction surveys and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the</p>	<p>FA</p>	<p>An interview with the group manager for resident wellbeing, verified a process existed for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family</p>

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>On admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident's bedroom.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, or monthly. A complex medical review occurs every three months and includes members of the multidisciplinary team. This is verified by documentation, interviews and observation.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident needs to meet their goals and desired outcomes.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to those concerned.</p> <p>Care plans are evaluated six monthly or more frequently as the residents condition dictated. Interviews, observation and documentation verified resident and family/whanau involvement.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of the facilities service provision.</p> <p>Residents and family/whanau members expressed a high level of satisfaction with the care provided.</p> <p>A wide range of equipment and resources was seen to be available that complied with best practice guidelines and met the resident's needs.</p> <p>A continuous improvement is awarded for the implementation of the staff walking programme in the</p>

		dementia unit.
<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>	FA	<p>The activities programme is provided by two trained diversional therapists and an assistant.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The residents activity needs are evaluated every three months as part of the three monthly medical reviews, in addition to being updated in the care plan as residents needs change or six monthly as part of the six monthly reviews. This addresses a previous corrective action request.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. A men's group (run by a male for the men), runs once a week and involves specific 'bloke' activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Regular events are organised and community participation is encouraged.</p> <p>Residents from the secure unit are able to attend activities in all areas, including those offered in the unit. Activities in the unit include outdoor activities that enable the residents to walk twice a day. Residents in the secure unit have reduced wandering at night due to their high activity levels during the day.</p> <p>A residents meeting is held six monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>	<p>FA</p>	<p>Policies and procedures describe waste management and chemical storage processes. In addition the infection control documentation includes a waste management section which includes policy and procedures for waste (blood and bodily fluids) management and disposal.</p> <p>The door to the chemical and cleaning store is locked. An external firm is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. In the cleaning storage area instructions for safe use and what to do if there is a spill is sighted. Cleaning products are all colour coded for ease of identification. The training records confirmed chemical and spill training is completed annually. The housekeeping staff interviewed were both able to detail process and procedures required for the safe use of all products.</p> <p>Aprons, gloves and masks are provided in the sluice rooms and in all areas where personal cares are involved including the laundry and the cleaning areas. Staff are observed using these throughout the facility as appropriate during the audit. Large 'outbreak bins' are located around the facility and staff report these are used as soon as any concern is noted.</p> <p>The exterior sheds where any gardening and maintenance substances are stored was secure and the doors was well labelled with appropriate signage. A Code of Compliance is competed annually for the outside chemical storage area.</p> <p>Any incidents are reported and documented. Both clinical and non-clinical staff report they are clear about the process for incident reporting in this area.</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 building warrant of fitness (WOF) sighted is current and expires on 11 November 2016. Regular testing of electrical equipment is completed and calibrations as necessary with a register kept. The facility is purpose built with wide hallways around the whole facility with handrails installed to assist with safe mobility for the residents. All mobility and hoisting equipment is stored safely. Hot water temperatures are recorded monthly and any variations responded to.</p> <p>A large number of sheltered outside areas and gardens are provided and these are easily accessed. An internal courtyard with vegetable gardens is a feature for residents who are keen to participate in gardening activity. The dementia wing has a range of gardens and outside areas for residents including an area where hens are kept.</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 ten full bathrooms located evenly around the facility. These are all spacious, hygienic and well maintained with locks on all doors to ensure privacy. In addition a number of toilets are also evenly spaced around the three wings. All toilets and bathrooms are well labelled with easily turned locks. Separate toilets are available for staff and visitors.</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>All the residents' rooms are fit for purpose and enable the safe use of any mobility equipment required. All are kept very clean and tidy with personal items an integral part of the furnishings and contents. The organisation has supplied wall televisions for all rooms to maximise space. Residents spoken with expressed satisfaction with their rooms and the facility environment. The respite rooms are also spacious and provide a homely atmosphere for those residents using the service.</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</p>	FA	<p>All three wings have large lounge areas and there are two spacious dining rooms. One of these is for the apartment residents but is also used by the facility residents who don't require assistance at meal times. The respite wing has its own lounge and dining area with its own kitchen facilities. A television with sky is provided in one of the larger spaces and this is used for big sporting events and other programmes of wider interest. There are a number of smaller spaces where residents and families can meet if they wish.</p> <p>A large activity room is well used and provides plenty of space to cater for the range of activities that take</p>

<p>areas to meet their relaxation, activity, and dining needs.</p>		<p>place.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Appropriate policies for cleaning and laundry services were reviewed. All linen is managed by an external contracted provider. Personal laundry including bed protectors and handtowels is done in house in the laundry by a designated staff member.</p> <p>An outside agency is also contracted to supply detergents two weekly and to maintain the machines which is done six monthly and as required. Data sheets were observed on the laundry wall to provide information on all products in use. They also provide appropriate chemical training for both cleaning and laundry staff.</p> <p>All laundry is cleaned according to the policy and guidelines and the laundry manager was able to detail the process used to ensure safe and hygienic management of all dirty, soiled and clean laundry. Colour coded laundry bags are used by all staff should there be any soiled laundry to be collected from rooms for transportation to the laundry and sluice areas. These were observed in use.</p> <p>Internal audits are done on a regular cycle both in the laundry and for the cleaning of the facility to monitor effectiveness with results being used to ensure standards are maintained.</p> <p>A cleaning schedule has been developed by the external agency that is contracted to do the common areas and all bathrooms and toilets. The facility staff manage the cleaning of resident's rooms and any other cleaning required after hours. Cleaning staff all wore appropriate protective clothing and manage their cleaning products appropriately.</p> <p>Resident satisfaction surveys show there were no concerns with the personal laundry services and the cleanliness of the whole facility was observed to be of a particularly high standard.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies / procedures and guidelines for emergency planning, preparation and response. There are disaster planning guides which direct the facility in their preparation for disasters and describe the procedures to be followed for fire evacuations and regular practices. There is a list of what supplies are held in the emergency civil defence room which is located in the apartment area. This area contains appropriate supplies for use in the event of an emergency. A stocktake was completed in July 2015. There are also a number of water tanks around the complex, three bar b ques and relevant tools that may be required in the gardener's storage area. There is a generator on site.</p> <p>Emergency evacuation procedures are located around the facility. There are seven fire cells and any evacuation is a staged one. A fire evacuation drill is held six monthly with the last one completed on 29 March 2016. This was observed by the fire department and documented to record no concerns identified.</p> <p>Staff training for emergencies occurs regularly and orientation includes an emergency training module. Civil</p>

		<p>defence training was completed in February 2016. An annual emergency quiz is also completed by all staff. The approved evacuation plan was sighted. This was completed in 2009. Staff have head lamps available. All rooms and hallways have smoke alarms and sprinklers.</p> <p>All rooms are equipped with a call bell which is monitored in the nurses' stations. Bells were observed to be answered promptly during the audit.</p> <p>The main doors are locked by 7 pm at the latest and all other doors and windows are checked. Security lighting is used in outside areas. A security firm patrols regularly each night and they check in with staff.</p> <p>Residents interviewed all felt safe and secure in the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Individual rooms and communal areas have opening external windows and most have doors that open onto outside garden or small patio areas. Heating provided is underfloor in all rooms and bathrooms with additional heat pumps in the communal areas. All areas are well ventilated with large windows that ensure plenty of natural light throughout.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection prevention and control policy reflects the requirements of the infection prevention and control standard (NZS 8134.3:2008). The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control programme.</p> <p>The infection control programme, reviewed annually, establishes, maintains and monitors procedures covering infection control practices.</p> <p>The infection control practices are guided by the infection control manual of an external infection control advisor, with assistance from the DHB infection control nurse where needed.</p> <p>It is the responsibility of all staff to adhere to the procedures and guidelines in the infection control manual when carrying out all work practices. Evidence of practice relating to these policies was sighted at audit. Reporting lines are clearly defined.</p>
<p>Standard 3.2: Implementing the infection control</p>	FA	<p>The infection control advisory committee includes a member from each service provision in the</p>

<p>programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>organisation, meets quarterly to discuss infection prevention and control processes.</p> <p>The two infection control coordinators who are responsible for implementing the infection control programme and report directly to the group manager for resident wellbeing. A position description is included in the infection control (IC) programme. One of the coordinators is a registered nurse and the other is a health care assistant.</p> <p>The IC's and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records sighted and interview verified the IC's attend regular ongoing training.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control programme includes an external provider's policies and procedures. Policies are current and signed off by the ICs.</p> <p>Staff interviewed verified knowledge of infection control policies. Staff were observed to be compliant with generalised infection control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection control and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure the content is relevant and understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication style, as verified by resident and family interviews.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>In line with Health and Disability Services Standards (HDSS), the infection prevention and control standard</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>(IC) (NZS 8134.3:2008), surveillance of infections is occurring as per the surveillance guide, and is the responsibility of the infection prevention and control nurses.</p> <p>Daily incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.</p> <p>Incidents of infections are presented at the monthly RN meetings and any ongoing corrective actions discussed and presented to staff at staff meetings, and to the infection control committee, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are benchmarked internally.</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>The organisation has a comprehensive suite of policies and procedures which meet the requirements of the restraint minimisation and safe practice standards with appropriate definitions provided. The restraint coordinator, who has been in the role for a number of years, provides support and oversight to the restraint management processes of the facility. In interview she demonstrated a sound understanding of the organisation's policies and procedures and these clearly guide practice.</p> <p>The policies and procedures emphasise that the use of restraint is a last resort and all alternatives are explored before restraints are used. This is also evident on review of the restraint approval group minutes and file records of those residents who have approved restraints. The use of restraints is minimised as much as possible while maintaining safety.</p> <p>On the days of audit there were five residents using enablers. In all cases the residents have requested the equipment in use and a similar process to that followed for the use of restraints is used for enablers. This provides for a robust process which ensures the on-going safety and wellbeing of the resident. In all cases the resident is voluntarily using the equipment and it is included in their care plan.</p> <p>Staff reported they were clear about the use of restraint and that enablers are voluntary and at the request of a resident. Regular training occurs and this is documented in the training plan.</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</p>	<p>FA</p>	<p>There is a restraint approval process and a restraint approval group. The group is made up of a range of staff from both nursing and care giving staff and the quality manager. All restraints are reviewed as part of the regular three monthly care plan review with the resident's primary nurse. This information is used by the approval group who meet regularly every three months and with a full organisational review and evaluation meeting six monthly.</p> <p>Restraints are used for safety only. Records were reviewed and confirmed that the restraint coordinator, in</p>

<p>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>consultation with the clinical services manager, have accountability and responsibility for restraint processes at Sevenoaks Lodge. The organisation's processes are implemented and the approval process is followed.</p> <p>On the days of audit there were twelve residents with approved restraints. It is evident from review of restraint approval group meeting minutes and collated data that the overall use of restraints is being carefully monitored and analysed.</p> <p>There is a position description for the restraint coordinator which describes the role and responsibilities. The meeting minutes and records on resident files demonstrate that the restraint coordinator has been undertaking the role as described.</p> <p>Residents who have approved restraints have all the appropriate approval documentation on their files. Their care plan includes reference to the current approved restraints in use. There is also evidence of family/whanau/EPOA involved in the decision making as is required by the organisation's policies and procedures. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</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 process includes all requirements of this standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The general practitioner is always involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process includes consent from the resident's family/whanau or EPOA, whomever is most appropriate. All residents using restraints at the time of the audit have a current assessment and consent form. All historical information and comments from any referrers are included in the assessment process as are any cultural considerations.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised. At interview with the restraint coordinator, she described how alternatives to restraints are discussed with family/whanau when they request restraints. Time is spent explaining how the resident can be safely supported and alternatives explored before use of a restraint is implemented.</p> <p>Restraint approval group meeting minutes record these discussions. Family/whanau interviewed confirm they are included in decision making.</p> <p>A restraint register is maintained by the restraint coordinator. It is updated every month and reviewed at every restraint approval group meeting. The register for all the current residents was reviewed. The register</p>

		<p>has been maintained throughout this time. Changes on the register reflect any changes in need as identified.</p> <p>Staff members interviewed reported that restraints are used as a last resort and only to ensure safety. They receive training in the organisation's policy and procedures and in related topics such as supporting people with challenging behaviours in positive ways. Their understanding is that the use of restraints is to be minimised as much as possible.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint approval group evaluates the use of restraints for every resident at least every three months. This includes a review and updating all the documentation relating the use of the restraint (ie, the assessment, consent, monitoring) and feedback is sought from all staff members involved in the providing care and support to each resident. Any changes since the last review are considered with the possibility of removing the restraint discussed for each person and carefully considered.</p> <p>All requirements of this standard are included in the evaluation of restraint use and are documented on each resident's file. This was confirmed on review of files during this audit.</p> <p>When restraints are in use they are monitored frequently to ensure the resident remains safe. The timeframe for monitoring is included in the resident's care plan and monitoring forms record that this occurs as described in residents' plans.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint committee undertake a six monthly review of all restraint use which includes all the requirements of this standard. This includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint are considered, the effectiveness of individual evaluations of restraint use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. An internal six monthly audit that is carried out also informs these meetings. Any changes to policies and guidelines are implemented if indicated. The restraint monitoring and quality review minutes dated October 2015 and April 2016 meetings were sighted and reflect the process is occurring as required.</p> <p>Interviews with staff members confirmed their understanding of a focus on safety, wellbeing and reducing the use of restraints as much as practicable.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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, 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>	CI	<p>An incident occurred in which police had to assist in locating a resident’s whereabouts after the resident, who did not require care in a secure unit, had gone for a walk and became lost. This incident identified an area of potential risk to residents who get lost and wander out of the facility grounds. An initiative was implemented to identify how to manage these residents, within a framework of independence, safety and security. A policy and assessment process was developed to identify residents who are likely to get lost whilst wandering, and then implement a strategy to allow them to continue to do so. Protocols are now in place, to manage the risk. This involved the installation of perimeter guards and the purchasing of wander bands which the resident wears, to enable staff to be alerted when the perimeter guards around the facility are breached.</p> <p>An evaluation of the effectiveness and the value of this initiative was sighted. In 2015, fourteen residents were identified as high risk, and were provided with wander bands. There were no incidents of these residents going outside the facilities perimeter guard without staff</p>	<p>A quality initiative was initiated to minimise the risks associated with residents going for a walk and getting lost, whilst allowing residents the ability to move about freely.</p>

		being aware. Documented evidence of resident and family interview verified satisfaction with the initiative which maximised residents independence and freedom whilst providing a safe environment.	
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	CI	<p>The service admits a high number of respite residents from a wide geographical area. Evidence sighted verified a high number of errors occurred in reconciliation data with GPs prescribing not being consistent with all aspects of resident medication needs. The GP was often unaware of specialist's prescriptions and over the counter remedies the resident was taking.</p> <p>An initiative was developed in collaboration with the DHB and the pharmacists. Prior to admission, respite residents get their pharmacist to generate a medication chart that records all the medications the resident is prescribed. The resident then takes the medication chart to their GP to get it signed. This accompanies the resident when admitted to the respite service. The implementation of this initiative has resulted in fewer errors, greater legibility, reduced time on reconciliation and reduced work for GPs.</p>	<p>A quality initiative was implemented to ensure the reconciliation and administration of respite residents' medication was accurate. Evidence sighted verifies a 55% reduction in medication reconciliation errors since the introduction of this initiative.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	CI	<p>In June 2015 it is noted that there was a high number of falls in the secure unit. Mapping of the falls identified, these occurred in the afternoons between 2 and 9pm, residents were more active and requiring increased supervision at this time. Staffing numbers were increased over this time, and the walking programme was increased to include walks during this time frame. Interviews and data sighted evidences an ongoing reduction in the number of falls since the introduction of this initiative.</p>	<p>A quality initiative was implemented in the secure unit to reduce the incidence of falls. The evidence sighted verifies a reduction in the number of falls, since the implementation of this initiative.</p>

End of the report.