

# Sunrise Healthcare Limited - Lynton Lodge Hospital

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## Introduction

This report records the results of a Provisional 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 Central Region's Technical Advisory Services 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:** Sunrise Healthcare Limited

**Premises audited:** Lynton Lodge Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical

**Dates of audit:** Start date: 24 June 2016 End date: 24 June 2016

**Proposed changes to current services (if any):** Lynton Lodge Hospital requires a provisional audit due to the pending sale of the facility to a new owner.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35



# Executive summary of the audit

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## 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

Lynton Lodge Hospital can provide care for up to 40 residents. This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process for certification included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer. The nurse manager is responsible for the overall management of the facility, including clinical care, and is supported by the managing director. Service delivery is monitored.

Improvements at certification, were required to the following: consent, resident agreements and advance directives; the quality plan; criminal vetting of staff and completion of interRAI assessments.

For the provisional audit, the current director and the clinical manager, as well as the prospective directors, including the new managing director, were interviewed. At the provisional audit the following areas still required signing off by the district health board; consent, advanced directives, the quality plan, criminal vetting of staff and interRAI assessments.

## Consumer rights

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

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

Staff are informed of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service. Information for residents and family members is accessible. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Residents and family interviewed confirm that consent forms are provided. Staff members confirm that time is provided if any discussions and explanation are required. Advance directives are completed by those deemed competent to complete these.

The nurse manager is responsible for management of complaints. Complaints documented on the complaints register are managed as per timeframes in 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.

Lynton Lodge Hospital has a documented quality and risk management system. There is a management system to manage residents' records with a document control process in place.

There are human resource policies implemented around recruitment, selection and orientation. Staffing is rostered to meet numbers of residents in the facility and acuity levels. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Quality improvement data is collected, collated, analysed and reported through scheduled meetings. Corrective action plans are developed and address areas identified as requiring improvement. There is an annual report documenting progress against all aspects of the quality programme. Risks are identified and the hazard register is up to date. Adverse events are documented on incident and accident forms and areas requiring improvement are identified.

Policies and procedures relating to human resources management processes govern their practices. Staff records reviewed provide evidence that their human resources processes are followed - apart from completion of criminal vetting. Staff education records confirmed in-service education is provided.

The provisional audit confirmed that the prospective providers will keep the reporting processes to the governing body the same with the directorship changing to the new providers. The managing director will manage financial decisions. Quality and risk management, adverse event reporting and service provider availability will stay the same except for the appointment of an administration manager who will also act as the receptionist.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Pre-admission information is accurately recorded and the information pack identifies the services offered. The service agreements meet the legislative requirements.

Services are provided by suitably qualified and skilled staff to meet the needs of the residents. The interRAI assessment process is an area identified to be improved. Timeframes for the development and review of the long term care plans are met. Short term plans are developed when there are changes in the resident's needs that are not addressed on the long term care plan.

The general practitioners review all residents medically at the required timeframes and more frequently as needed. Referrals to other health and disability services are planned and coordinated, based on the individual needs of the resident.

The activities programme meets the social and recreational needs of the residents. Activities are planned and are meaningful to residents. Residents are encouraged to maintain links with the community and the family/whānau.

A safe medication system was observed during the audit. The registered nurses are responsible for medication management and have completed competencies and relevant ongoing training to perform this role.

The residents' nutritional requirements are met by the service with preferences and special diets being catered for. Staff who prepare the meals are all experienced and prepare meals from a menu plan which has been approved by a dietitian.

## 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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There is a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help, when needed, in a timely manner.

The provisional audit confirmed that the prospective providers do not currently plan any environmental changes to the service.

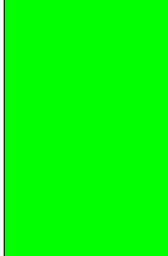
## Restraint minimisation and safe practice

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 service has well documented policies and procedures for restraint minimisation and safe practice. The staff interviewed have a good understanding of restraint and enabler use. Enabler use is voluntary and the least restrictive option is used. Four residents are using an enabler and six are using restraints. Environmental restraint is in practice by locking of external doors for safety and security. The processes for restraint include signed consent and information packs for residents and families.

Monitoring of restraints and evaluation of restraint use is effectively managed. Staff demonstrated a knowledge and understanding of restraint and the use of enablers.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control management system is appropriate for the size and type of this service. The programme is reviewed annually and implemented. Infection prevention and control reduces the risk of infections to residents, staff, families/whānau and visitors. Policies and procedures are available to guide staff. Staff are provided with relevant education, as are residents, when appropriate.

The infection control coordinator collates the monthly surveillance data and reports this to the nurse manager. Where any trends are identified action is implemented. The infection surveillance results are reported at the staff monthly forums. Expertise is available and can be sought as required. Benchmarking occurs against other comparable services, three monthly, and an annual report is developed and implemented.

## 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)
<b>Standards</b>	0	46	0	3	1	0	0
<b>Criteria</b>	0	96	0	4	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents state that they receive services that meet their cultural needs and they receive information relative to their needs. Residents state that staff respect their wishes.</p> <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the education programme with this provided in 2016. Staff are able to explain rights for residents in a way that promotes choice. The posters identifying residents' rights are displayed in the facility.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	PA Low	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent however this should be updated to include consent for transporting of residents. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent is signed for the following: routine cares and procedures; information to be collected; sharing of information with family; the listed routine procedures to be carried out; visiting personnel/students and use of a photograph. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the nurse manager discusses informed consent processes with residents and their families during the admission process.</p> <p>Most residents sign an admission agreement on entry to the service. An improvement is required to signing of admission agreements.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files confirms that the doctor signs the advance directive and an improvement is required.</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>	<p>FA</p>	<p>Staff state that written information on the role of advocacy services is provided to residents at the time of entry to the service. Resident information around advocacy services is included in the information pack given to new residents and/or family and there is information available at the entrance to the service around advocacy services.</p> <p>Staff training on the role of advocacy services is included in training on The Code and this was last provided for staff in 2016.</p> <p>The Health and Disability advocate visits the service during the year as confirmed by the management team and through meeting minutes.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.</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>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.</p> <p>Families interviewed confirm they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents' files reviewed demonstrate that progress notes and the content of care plans</p>

		<p>include regular outings and appointments with a van able to take residents into the community.</p> <p>One young resident confirmed that they are supported to access the community and they continue to engage in activities relevant to their needs. Other residents confirmed active involvement with family and friends in the community.</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>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and evidence of resolution of issues.</p> <p>The complaints register includes documentation of verbal complaints. Evidence relating to each lodged complaint is held in the complaint's folder. A complaint lodged in 2016 was reviewed and indicates that the complaint is investigated promptly with the issues resolved in a timely manner. The complainant signed the form indicating that they were happy with the outcome.</p> <p>The manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The nurse manager or a registered nurse discusses the Code, including the complaints process, with residents and their family on admission. Discussions relating to the Code can also be held at the resident meetings. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes reference to the poster of the Code displayed in the facility. Information around rights can be produced in a bigger font, if required.</p> <p>Information is given to next of kin or enduring power of attorney (EPOA) or family to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>For the provisional audit the prospective providers confirmed their understanding of consumer rights and that they must be adhered to, this was confirmed during interview of the prospective directors, including the managing director.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessments gain details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the service reports for 2015 or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Staff interviewed are aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The organisation has a cultural policy which outlines the processes for working with people from other cultures. The rights of the residents/family to practise their own beliefs are acknowledged in the policies documented.</p> <p>The nurse manager has had links with Ngāti Whātua in the past and is cultivating relationships currently with a local marae. Cultural needs are identified in the residents' care plans.</p> <p>Staff are aware of the importance of family/whānau in the delivery of care for the Māori residents. Staff have had training around cultural rights, safety and Māori in 2015.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice.</p> <p>Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. There are residents in the service for whom English is a second language. The service has staff who can speak their language and family are actively engaged in their care. One resident interviewed who does not speak English fluently stated that they are very happy with the care and treatment provided.</p>
<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>The facility implements policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.</p> <p>Job descriptions include responsibilities of the position and an outline of expectations with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p> <p>All registered nurses have completed training on the code of conduct and professional boundaries in 2015.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Lynton Lodge Hospital implements policies to guide practice. A quality framework supports a programme that includes all aspects of service delivery. There is evidence of monitoring of the service with improvements noted.</p> <p>There is a training programme for all staff and registered nurses are encouraged to complete training provided by the district health board.</p>

		<p>Residents and families interviewed expressed a high level of satisfaction with the care delivered. The level of satisfaction was also expressed in annual satisfaction surveys in 2015. The general practitioner interviewed expressed satisfaction with the clinical oversight and care provided.</p> <p>Consultation is available through the organisation's management team that includes the nurse manager and managing director.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident or has a change in health or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings. Two family members who visit daily both stated that they 'check' that cares have been provided in a timely manner and both stated that they had no complaints with services provided. This included two hourly turning of one resident, continence cares and checks performed by staff at least hourly.</p> <p>Interpreting services are available through the district health board and family interpret for resident who require this in the service.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Three directors provide oversight of the service. One is designated as the managing director and they were on site during the audit. The managing director is an enrolled nurse (EN) with a current annual practicing certificate and they meet with the nurse manager weekly. There are two monthly meetings between the directors with a report from the nurse manager tabled at the meeting. All risks are confirmed by the managing director as being escalated to the directors appropriately.</p> <p>The nurse manager has a current practising certificate and has worked as a registered nurse in the service for 16 years with six of those in the management role. They complete training in management and leadership one to two yearly.</p> <p>There is a philosophy, values and goals documented in the strategic plan 2016-17. The strategic plan is reviewed annually with a comprehensive annual report documented by the nurse manager. The report is tabled at the management meeting. The philosophy is communicated to residents, staff and family through information in booklets and in staff orientation and training.</p>

		<p>The facility can provide care for up to 40 residents requiring hospital level care with two designated bedrooms for rest home level of care. During the audit there were 35 residents living at the facility requiring hospital level of care. One resident was identified as a young people with disability on a chronic care long term contract. There are three residents identified as being under 65 years. Thirteen residents are privately paying.</p> <p>At the provisional audit the auditor established that the prospective providers intend to continue with the quality processes as set out in the previous provider's quality plan. The current director will provide orientation and induction to processes and the clinical manager will stay on in charge of the clinical services. The prospective managing director is a qualified chartered accountant and will oversee financial matters. Reporting processes will stay in place but reports will be to the new directors. The prospective providers' transition plan is to keep all operational processes the same with only the directors changing. The current providers did not have a receptionist at the time of the audit and the prospective providers are planning to have an administration manager/receptionist start orientation and induction before the takeover of the facility. Orientation and induction of the administration manager/receptionist will be undertaken by the current director and will include creating payroll and monitoring reports for the district health board and when needed to HealthCERT. Additional timeframes depend on the outcome of the provisional audit.</p>
<p><b>Standard 1.2.2: Service Management</b></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>	<p>FA</p>	<p>In the absence of the nurse manager, a registered nurse (RN) is appointed as second in charge with support from the directors. The current RN appointed to the role is newly appointed as second in charge and the nurse manager is in the process of formalising the role with the RN. The RN has been working in the service for three years.</p> <p>The nurse manager who is also the clinical manager at the service will continue to manage clinical services with the support from the prospective directors. The prospective managing director will make financial decisions and the administration manager will be in charge of the office/administration matters.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>PA Low</p>	<p>Lynton Lodge Hospital uses the quality and risk management framework that is documented to guide practice.</p> <p>A comprehensive quality plan is documented and this includes objectives and indicators with progress documented through monthly, quarterly and annual reports. The plan focuses on all aspects of the quality programme, however an improvement is required.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are expected to be reviewed two yearly and all have been reviewed in a timely manner. Policies are</p>

<p>improvement principles.</p>		<p>readily available to staff in hard copy. The policy around pressure injuries (PIs) has been updated to include recent information from the Ministry of Health.</p> <p>Service delivery is monitored through complaints; review of incidents and accidents; surveillance of infections; PIs; wounds; two monthly reports around health and safety and monthly reports around service delivery. The corrective action plans are documented and evidence resolution of issues is completed.</p> <p>Progress against indicators are discussed at meetings including the monthly staff forum; quarterly health and safety; quarterly service continuum; three monthly resident forums; two monthly quality meetings; restraint meetings three times a year and weekly management meetings. Family are able to attend the resident meetings if they wish. Staff report that they are kept informed of quality improvements and can talk about improvements made to the service.</p> <p>The last satisfaction survey for family and residents shows a high level of satisfaction and this was confirmed by residents and family interviewed.</p> <p>The organisation has a risk management programme in place. An organisational risk management plan is documented and reviewed annually. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated.</p> <p>The provisional audit confirmed that the quality processes of the current provider will continue to be used by the prospective provider and that the only changes will be the change to the directors and the appointment of an administration manager/receptionist. Policies and procedures will stay the same.</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>The nurse manager is aware of situations in which the service would need to report and notify statutory authorities, including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury (PI); infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board have been notified of any sentinel events, including, reporting of PIs to the Ministry of Health.</p> <p>Staff receive education on the incident and accident process during orientation and as part of the ongoing training programme. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</p> <p>Most residents are identified as being frail and elderly. There are a high number of incidents documented</p>

		<p>which may be reflective of the high level of dependency. The annual report from 1 January 2015 to 31 December 2015 recorded a total of 278 incidents including 72 falls. There has been a project around reducing the number of falls in 2015. The annual report states the total number of falls has reduced by 58% from the previous year (link to 1.3.4). Further projects are currently being undertaken to reduce the number of PIs.</p> <p>There are no legislative compliance issues or concerns regarding the takeover of the prospective provider. All quality indicators, including adverse event reporting will continue to be managed in the same manner.</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>	PA Low	<p>The registered nurses (RNs) and the manager hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files include appointment documentation including signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal. Criminal vetting has not been documented and an improvement is required. There is a low turnover of staff.</p> <p>All staff complete an orientation programme and health care assistants (HCAs) are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. HCAs confirm their role in supporting and buddying new staff. A new staff member interviewed confirmed that they had completed an orientation programme.</p> <p>The organisation has an annual education and training programme. Staff attendances are documented for internal training with evidence that there is good attendance at training sessions. RNs attend training provided by the district health board, including: wound management; PIs; pain management; preceptorship for new graduates; nutrition in 2015/2016. The pharmacy provides training annually around medication administration and management. Education and training hours are at least eight hours a year for each staff member.</p> <p>Two of the nine RNs have completed interRAI training and two other RNs are currently enrolled in the training. The nurse manager has completed the nurse manager training and administrator has also completed interRAI training relevant to the role. Staff have completed training around PIs in 2015 and 2016.</p>
Standard 1.2.8: Service Provider Availability	FA	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>bed occupancy.</p> <p>At certification there were 41 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a registered nurse (RN) on each shift. The nurse manager and RNs are on call. If the manager is on leave, a RN takes the on call role. Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</p> <p>Staff numbers at the provisional audit were 46, excluding the clinical manager. Staff will retain their positions and the prospective providers intend to continue with the education and training programme of the current providers. The two new directors will form the governance body, with one of the directors acting as the managing director. The current clinical manager will stay in this position but may have a change of title in this role.</p> <p>The prospective providers will be taking over the current policies of the service and continue to use the policies for guiding service provision, this include the current skill mix policy.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.</p> <p>Entries are legible. Entries are dated and signed by the relevant healthcare assistant, RN or other staff member, including their designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff state that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p>	<p>FA</p>	<p>The service has a pre-admission and admission system. The hospital administrator was the front person for enquiries and is experienced in this role. There is an information pack and brochures about the facility and services provided. All residents currently using this service have been assessed as hospital level care, however, two rest home beds are available as part of the agreement with the DHB. The resident service agreement is based on the Aged Care Association Agreement which is individualised to the</p>

<p>equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>service. Any charges that are not covered by the service agreement are clearly documented. There are adequate stocks observed of continence and wound care products to meet the needs of the residents.</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>	<p>FA</p>	<p>The RN interviewed stated that any risks identified prior to discharge or transfer are documented. A transfer form is used and the DHB (yellow bag system) is utilised. The RNs ensure open disclosure between services and family/whānau related to all aspects of service delivery occurs. This includes residents for either discharge and/or transfer to another facility or the DHB.</p> <p>If there are any specific requests or concerns that the resident or family want discussed, these are noted on the transfer form. The discharge summary and copy of the care plan summary is provided and covers all personal care and needs of the resident and any interventions required. Any identifying risks, alerts or concerns are highlighted. If a transfer occurs a copy of the medication record, the resident information record and any advance directives also accompany the resident. If transferred to another facility a full interRAI assessment is required to be completed. Family are kept well informed throughout the process.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing and recording processes when an error occurs. The sighted policies meet the legislative requirements and best practice guidelines.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of the audit. Medicines are stored in locked medicine trolleys in the storeroom. Medicines that required refrigeration are stored separately in a fridge. Controlled drugs are managed effectively and are secured in a locked cupboard and locked room. The controlled drug register is well maintained and balances are checked and are correct.</p> <p>The medication records reviewed are reviewed by the GP regularly - at least three monthly and at time of visits, if needed. This is evidenced on the records sighted. All prescribed medicines reviewed contained the date, medicine name, dose and time of administration and maximum dosages as required. All medication records have photo identification. Medicine signing sheets are completed at time of administration.</p> <p>No residents self-medicate. A policy was reviewed.</p> <p>There are documented competencies for the RNs to complete annually.</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 kitchen is managed by an experienced qualified chef who is responsible for the ordering of all food, equipment and resources utilised in the kitchen. Cleaning schedules are developed and implemented. The kitchen is well designed and functional with clean and dirty flows for infection prevention and control purposes. All staff completed hand hygiene and food handling training. Certificates are displayed in the dining room. Guidelines are available for cleaning, temperature control management requirements, hygiene standards for staff, purchasing of food, checking, storage and waste management processes. Regular surveillance of the food preparation is performed by the Chef.</p> <p>The Chef works Monday to Friday and a cook is available at the weekend and for relief duties.</p> <p>There is a five week cycle for the menu plans with summer/winter variations. The menu is reviewed, two yearly, by a contracted dietitian. The menus are displayed daily on the blackboard provided. When unintentional weight loss occurs with a resident the GP is notified and the resident is reviewed. A dietitian is involved, as required, on a referral basis.</p> <p>A nutritional profile is completed for each resident by the RN when the resident is admitted to the service. A copy is provided to the Chef. Any food preferences are noted or special diets to be catered for are considered and arranged. The family/resident interviewed reported they are satisfied with the food and fluid services.</p> <p>Food procurement is the responsibility of the Chef. Fridge and freezer temperature recordings are observed daily and recorded to meet food safety requirements. Education is provided and is ongoing for all staff. Special occasions such as birthdays are celebrated with fresh home baking done on a daily basis. All meals and including morning, afternoon tea and supper are provided. Supplement drinks are provided, as required, for residents to meet their needs.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The registered nurse interviewed reported that the service does not refuse a resident if they have had a suitable needs assessment (NASC) for the appropriate level of care and there is a bed available. The service accepts residents that are hospital level with advanced dementia .In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be arranged. Interpreter services are available if required. The resident register is maintained and updated by the administrator.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	<p>PA Moderate</p>	<p>The interRAI summary is only evident in the files when full assessments are being completed. A schedule is developed and implemented to review all residents and this included the full interRAI assessment. Any new residents admitted to the service or those being transferred have an assessment completed. The two</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>current registered nurses who are fully interRAI trained to complete the interRAI assessments as required are working through to meet this requirement. One interRAI trained RN has recently resigned and one is on maternity leave. All residents have comprehensive care plans which are all current.</p> <p>Residents, staff and families interviewed reported appropriate care is provided that meets the identified support needs and preferences.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' records reviewed have comprehensive care plans that address the resident's abilities, level of independence, identified needs/deficits, and takes into account the residents habits and idiosyncrasies. The strategies minimising falls risk on assessment are use of techniques that are effective for managing challenging behaviour in the records reviewed is evident. The records evidencing interRAI assessment summaries includes triggered outcome scores and the needs, identified by the RN completing the individual assessment. These findings are documented onto the existing care plan.</p> <p>The nurse manager and the RN interviewed demonstrated they understand the interRAI process and this will be implemented for the reviews as documented.</p> <p>The individual care plans and individual activities plans identified resident's activities, motivational and recreational requirements with documented evidence of how these are managed effectively for each individual resident.</p> <p>The residents' records sighted demonstrated service integration and service delivery plans that were developed after appropriate assessments had occurred.</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>	<p>FA</p>	<p>Support and care is individualised and focused on achieving desired outcomes/goals set. The registered nurses (RNs) and healthcare assistants (HCAs) interviewed demonstrated appropriate skills and knowledge of the individual needs of the residents. The records reviewed evidence of consultation and involvement of the resident and family as able. The residents/family interviewed reported satisfaction with the care and services provided.</p> <p>Short term care plans are developed and implemented as necessary and for any event that is not part of the long term care plan, such as unexplained weight loss, pressure injury or wound care management. The RN ensures the general practitioner (GP) is kept well informed of progress. The GP interviewed confirmed this.</p> <p>The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plan reviewed demonstrated interventions that are consistent with the resident's needs being able to be met. Observations on the day of the audit indicated residents are receiving care that is</p>

		<p>consistent with meeting their assessed needs. The RN interviewed reported that all care plan interventions are accurate and are up-to-date. The nurse manager is kept well informed of any significant changes.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 ensures resident's individual motivational, recreational and cultural needs are recognised. Each resident is assessed by the activities coordinator (AC) on admission. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The AC resigned two weeks ago and a fully qualified diversional therapist is commencing the role next week. The current activities programme was reviewed.</p> <p>The programme is planned monthly and displayed on a daily basis at the entrance to the facility and in the lounges. Residents and families can access the information displayed. Attendance records are maintained. Each resident has their own activities plan which is reviewed, six monthly, or earlier if required. The staff involved in the interim time are fully aware that resident participation is voluntary and this is respected. A private occupational therapist can oversee the activities programme and is utilised to ensure residents have appropriate equipment and resources to maintain independence as required.</p> <p>Residents are encouraged to maintain links with the community and family. The service has a bus trip every Wednesday and healthcare assistants assist if and when required. (There is a link with 1.3.7.1 to 1.1.10.4 in regard to consent forms for transportation to be addressed). Communion is arranged and a church service is held monthly.</p> <p>Students from Secondary School Centre work at the facility as volunteers every Wednesday 9am –12pm then go back to school. Mostly assist with activities and one on one with those residents who are unable to attend the group activities.</p> <p>Special days are celebrated. Recently a Red Nose Support Day was held for Cure Kids and the money raised was donated to this cause.</p> <p>At the time of the audit residents were visibly enjoying activities in progress and residents interviewed reported that they enjoy the activities and outings arranged.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluation of care plans occur six monthly or earlier if applicable. Evaluations are focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the set goals. If a resident's needs change or if the resident is not responding appropriately to the interventions being delivered then this is discussed with the nurse manager, GP, the resident and the family. Short term care plans are initiated as needed.</p>

		<p>Staff interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover sessions between shifts. This was observed. Progress is also discussed at the six monthly reviews.</p> <p>Families reported that they are consulted when staff have any concerns or when there are changes to the resident's condition.</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 are provided with options, if required, to access other health and disability services. There are two GPs that are contracted to this facility and both visit their residents regularly. The GPs cover the after hours, if required, and cover twenty four hours a day seven days a week. The GPs arrange any referrals to specialist medical and/or surgical specialists as required. There is a process for transferring residents, if and when required. The DHB referral system is followed and is a guide for the GP and staff after hours.</p> <p>The RN interviewed reported that the referral services respond promptly to referrals sent and emergency services as needed. Records of the processes maintained was confirmed in the residents' records reviewed which included referrals and consultations with eye specialists, vascular clinic, radiology, physiotherapist, podiatrist and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed. Copies of correspondence and referrals are retained in the individual resident's records.</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>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognised risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
Standard 1.4.2: Facility	FA	A current building warrant of fitness is displayed – expiry date May 2016. There have been no building

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>modifications since the last audit.</p> <p>There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses and cushions; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirm there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are decks and grass areas with shade, seating and outdoor tables.</p> <p>The prospective providers do not have any current plans for making environmental changes to the service.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers.</p> <p>Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</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>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment there is sufficient space for both the equipment, for example, a hoist and at least two staff and the resident, with the ability to include emergency equipment in the room, if required.</p> <p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required.</p> <p>Some bedrooms are shared by up to two residents (refer 1.1.10).</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>	<p>FA</p>	<p>The service has lounge/dining areas in each wing of the hospital and other areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining area has ample space for residents. Residents can choose to have their meals in their room.</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>Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is managed. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit around keeping the trolley in sight.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p> <p>Cleaners and laundry staff state that they receive training from the company that provides chemicals and this is documented.</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>An evacuation plan was confirmed as being approved by the New Zealand Fire Service in 2015. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff, six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member with a first aid certificate on duty.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas BBQs.</p> <p>An electronic call bell system uses display boards throughout the facility. There are call bells in all</p>

		<p>resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bells are monitored to ensure that they are answered promptly and that all are operational. Residents and family state that there are prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place.</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>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature.</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 service has a documented infection control (IC) programme which is reviewed as part of the annual quality review of the whole programme. The IC programme minimises the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator (ICC) is an experienced registered nurse (RN). The IC position description sighted has clear guidelines for the accountability and responsibility, contained in the IC manual. The ICC monitors the infections, uses standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. IC is a standing agenda item in the staff forums. If there is an infectious outbreak this is reported immediately to staff, management and where required, to the DHB and public health departments.</p> <p>The ICC interviewed reported that the staff have good assessment skills in the early identification of suspected infections. Residents with infections are reported to staff at handover, have short term care plans and documentation in the progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at the main entrance. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, though the ICC reports that this can be difficult at times with residents with cognitive impairment.</p> <p>The RNs and health care assistants interviewed demonstrated good infection prevention and control</p>

		techniques and awareness of standard precautions, such as hand washing.
<p>Standard 3.2: Implementing the infection control 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>	FA	<p>A RN is the designated IPCC and has been in this role for three years. The ICC reports to the nurse manager. The service contracts a professional service to collate all IC information and bench marking occurs against 79 like services. This hospital's benchmarking IC outcomes rated third overall in 2015. The monthly reports along with any issues and results are presented at the quality forums and any feedback is given to staff.</p> <p>There have been no infection outbreaks since the previous audit. Further external advice on infection prevention and control issues is available if and when required from the DHB IC nurse specialists, the diagnostic contracted service microbiologist and the GPs.</p> <p>The ICC undertakes courses in infection prevention and control through the in-service education programme and updates from the DHB.</p> <p>The RNs and healthcare assistants demonstrated good knowledge of infection prevention and control.</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>An IC policy sets out the expectations the organisation uses to minimise infections. This is supported by an IC manual and a large suite of policies and procedures which deal with the specific areas, including antibiotic use, MRSA screening, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. They are easily understood and appropriate for service requirements.</p> <p>Policies included IC roles and key responsibilities which are signed off appropriately by management and the objectives of the IC programme. The IC programme, quality and risk plans are closely linked to the quality and risk management system.</p> <p>Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers,</p>	FA	<p>IC education is included in orientation and is part of the ongoing in-service education programme as sighted on the training record. The infection prevention and control education is provided by the ICC and the nurse manager, as required. The ICC has sound knowledge of current accepted good practice in infection prevention and control.</p>

support staff, and consumers.		<p>The education focus for all staff covers topics such as standard precautions, hand hygiene, handling of soiled linen, wound care management, and vaccinations such as the influenza vaccine offered to staff and residents annually.</p> <p>Resident education is conducted as required. The nurse manager evaluates all IC education and records are maintained.</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>	FA	<p>The acting clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example, facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/ICC. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the IC programme. IC processes are in place and documented.</p> <p>The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short term care plans and the infection were entered on the infection log.</p> <p>The ICC/RN is responsible for the surveillance programme. Surveillance analysis is completed and reported at some meetings (refer to 1.2.3). In interview, the manager/RN confirmed no outbreak occurred at the facility since last audit.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and short term care plans. This was evidenced during attendance at the staff handover and review of the residents' files.</p> <p>The IC surveillance that is undertaken is appropriate to the size and complexity as shown in the IC programme. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is clearly described in the quality plan and management meeting minutes, to describe actions taken to ensure residents' safety. Any IC alerts are documented on the individual resident's records reviewed.</p> <p>There is a monthly surveillance report. The service monitors urinary tract infections (UTIs), eye infections,</p>

		<p>respiratory tract infections, wound care infections, multi-resistant organisms, diarrhoea, vomiting and other infections. The monthly analysis of the infections includes comparisons with the previous month's results, reasons for increase or decrease and actions taken to reduce infections. The analysis includes the feedback that I provided to staff. Results are clearly displayed on the quality assurance board.</p> <p>An external contractor benchmarks surveillance data.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There were ten restraints and four enablers in use at the time of the audit. The restraint minimisation and safe practice policy and procedures have been reviewed. There are clear definitions of restraint and enablers. Enablers are described in accordance with the Health and Disability Sector Standards requirements. The use of enablers is voluntary and the least restrictive option. Staff interviewed have a good understanding of the organisations philosophy to minimise the use of restraint.</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>Policies and procedures are in place to guide staff and to allow staff to use restraint safely, if and when required.</p> <p>The restraint register was reviewed and was maintained by the nurse manager, who is the restraint coordinator.</p> <p>Education records sighted evidenced staff received appropriate education on restraint minimisation and safe practice. De-escalation training was provided for managing challenging behaviour situations. The nurse manager ensured the education records were current and up-to-date.</p> <p>Restraints in use included lap belts, bed rails, chair and environmental restraint for two residents. The front door is locked and has key pad access/exit. The door opens automatically in the event of the fire alarm sounding. Informed consent is obtained from resident/family/representatives and a restraint use information booklet is given to all families accessing the facility. The code is clearly displayed above the doorway on either side. The reception office is located in the entrance and visitors report to the receptionist or ring the bell for assistance of staff.</p> <p>Interviews with family/residents confirm they are able to exit the building anytime.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	FA	<p>Each of the residents records reviewed for restraint contained a comprehensive account of the assessment made prior to restraint use. These included current falls risk, a history of incidents, alternatives tried and reasons for the assessment being conducted. All risks associated with the use of restraints were identified and highlighted. Culturally safe practice was maintained throughout</p>

relation to use of restraint.		restraint/enabler use, as required. Staff have received training in de-escalation methods as per the training programme and attendance records sighted.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The nurse manager interviewed stated that the service is aiming to reduce the amount of restraint in use through the purchase of appropriate beds, alarm mats and the emergency door alarms. Any alternatives considered and trialled were documented in the restraint forms and in the resident's restraint management plan.</p> <p>Healthcare assistants and staff are aware of alternatives and seek new ideas. All staff complete an annual restraint competency test.</p> <p>The restraint register is updated each month and records the resident name, the type of restraint/enabler in use, when it was initiated and when it is due for review and the date discontinued. Advocacy and support is available and can be accessed as required.</p> <p>Staff receive restraint minimisation education and a competency assessment questionnaire for the minimisation and safe use of restraint was implemented. Safety is promoted at all times.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Documents including restraint care records and staff interviews confirm that ongoing restraint use is appropriately evaluated and reviewed by the restraint coordinator at three monthly intervals. An evaluation and review form is completed and filed in the individual resident clinical record. The purpose of the evaluation is to promote the safe use of restraint/enablers, to minimise the use of restraint/enablers, to determine if the intended outcomes long and short term are achieved or not for each situation where a resident has been restrained.</p> <p>The care plan is updated and currency maximised. The outcome from the resident's perspective is sought in view of support and advice offered and the staff perspective included any incidents/complaints or outcomes of interest. Staff state they try different approaches to reduce restraint use and minimise unwanted and challenging behaviour.</p> <p>The restraint coordinator and registered nurses maintain ongoing communication with families and support to staff. The service provider has complied with the requirements of this standard.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the	FA	The restraint coordinator conducts monthly reports which are presented at the quality meetings, held quarterly. Minutes were available for review. The restraint approval group meets three times a year. The annual report was sighted evidencing quality monitoring does occur inclusive of recording the type of

<p>monitoring and quality review of their use of restraint.</p>		<p>restraints used, frequency of use, consent forms are signed and restraint assessments are performed appropriately, de-escalation techniques are utilised, consumer satisfaction, family/whānau satisfaction, individual restraint evaluations, restraint education and audits being performed and reported monthly and presented at the staff forums. The quality review considers trends in restraint use, compliance with policy and procedures, any adverse events related to restraint use and staff education and competence. Strategies in place to reduce restraint use are succeeding.</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)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>Resident files identified that informed consent is signed for routine cares and procedures and the information to be collected; sharing of information with family; the listed routine procedures to be carried out; visiting personnel/students and use of a photograph. All files reviewed included a signed consent form. The manager and staff state that residents are transported for activities into the community. A new form has been developed for residents to sign giving consent and this is to be introduced in April 2016.</p> <p>Residents are required to sign an admission agreement on entry to the service. Five files reviewed indicate that an agreement is signed in three files. One file is for a resident who was admitted over 10 years ago and an admission agreement is not signed. One file was for a resident admitted over three months ago and the agreement is with the EPOA. One file was for a resident admitted in the latter half of 2015 and the agreement was signed 11 days after admission. The sample size was increased by two other files for residents who had been admitted in 2016. Both had been signed 11 days or more after admission.</p>	<p>Consent for transporting of residents and/or sharing of a bedroom is not documented and signed.</p> <p>Admission agreements are not always signed on the day of admission.</p>	<p>Ensure that consent is signed by each resident for transportation and for sharing a bedroom with another resident.</p> <p>Ensure that the resident agreement is signed on the day of admission.</p>

				180 days
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. The policy states that only the resident deemed competent can make an advance directive. A review of files confirms that the doctor deems the resident competent to make decisions around cares. The doctor confirms on the advance directive form that there have been discussions with the resident around resuscitation and they tick to indicate if the resident wishes to be resuscitated as a treatment option. The doctor signs the form for any resident deemed competent to make an advance directive.</p>	<p>The doctor signs the form indicating for or not for resuscitation.</p>	<p>Ensure only residents deemed competent sign advance directives.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>A comprehensive quality plan is documented and this includes objectives and indicators with progress documented through monthly, quarterly and annual reports. The plan includes all aspects of the quality programme but does not clearly detail issues, activities that will be addressed in the forthcoming year or are being addressed currently as part of the quality improvement programme.</p> <p>Projects are documented as issues arise and there is evidence of quality action plans completed. Reports against quality action plans are documented.</p>	<p>The quality plan does not identify clearly the key activities currently being improved in the service along with accountabilities and timeframes.</p>	<p>Document key activities currently being improved in the service in the quality plan and include timeframes and accountabilities.</p> <p>180 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>There is a policy around recruitment. All staff have signed contracts and evidence of other documentation related to their appointment including a curriculum vitae, referee checks and an application record.</p>	<p>Criminal vetting is not completed for new staff and have not been completed in the past.</p>	<p>Complete criminal vetting for all staff.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs,</p>	PA Moderate	<p>Resident records were randomly selected to review. The RNs and nurse manager were interviewed. Training records were reviewed. Residents/family</p>	<p>Currently 15 of 35 residents do not have an</p>	<p>To ensure all residents have an interRAI</p>

<p>outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>		<p>interviewed were pleased that their needs are being effectively met.</p>	<p>interRAI assessment or summary completed.</p>	<p>assessment completed.  90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.