Aberleigh Rest Home Limited - Aberleigh Rest Home

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 Health and Disability Auditing New Zealand 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:	Aberleigh Rest Home Limited
Premises audited:	Aberleigh Rest Home
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 June 2016 End date: 10 June 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: 53

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

Dementia Care New Zealand Ltd (DCNZ) is the parent company of Aberleigh Rest Home. The service provides care for up to 62 residents across four service levels (psychogeriatric, hospital, rest home and dementia). On the day of audit, there were 53 residents.

The service is managed by a clinical manager with support from an operations manager. The operations manager and the clinical manager are experienced in their roles. Family interviewed all spoke positively about the care and support provided.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management, staff and General Practitioner.

The service is commended for achieving continued improvement ratings around good practice, implementation of the quality system and education.

The audit identified that improvements are required around: progress notes, hot water temperatures and registered nurse staffing for the psychogeriatric unit.

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

Aberleigh Rest Home provides care in a way that focuses on the individual resident. Cultural and spiritual assessments are undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified on-going involvement with community.

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.

Aberleigh Rest Home is implementing the DCNZ quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents and accidents are appropriately documented and managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is a well-developed education programme in place that is support from the head office. This includes training packages for all level of nursing staff. External training is supported. There is a staffing policy and rosters in place.

Continuum of service delivery

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

A comprehensive information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices particular to the secure units. The operations manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were based on the InterRAI outcomes and other assessments. They were clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. There is at least a three monthly resident review by the medical practitioner and psychogeriatric community nurse as required. The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans have been developed in consultation with resident/family.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. There are regular visits and support provided by the community mental health team and psycho-geriatrician.

The food services is provided from the main kitchen and delivered in hot boxes to the small home kitchenettes. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period. There is dietitian review and audit of the menus. All staff have been trained in food safety and hygiene.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.

The building has a current building warrant of fitness. There is a planned maintenance schedule. There is adequate space in the facility for storage of mobility equipment. Resident's rooms, lounge areas and the environment is suitable for residents requiring rest home, hospital dementia and psychogeriatric levels of care. Outdoor areas are safe and secure and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained. All chemicals are stored safely. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff regularly receive training in emergency procedures.

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.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. There are three residents using restraints and no residents utilising enablers. A register is

maintained by the restraint coordinator/registered nurse (RN). Residents using restraints are reviewed a minimum of six-monthly by the approval group. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

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.

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (a registered nurse) is responsible for coordinating/providing education and training for staff. The quality team support the infection control coordinator. Infection control training has been provided within the last year. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Dementia Care NZ (DCNZ) facilities

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	2	45	0	3	0	0	0
Criteria	5	93	0	3	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	Aberleigh Rest Home has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed (six caregivers, one diversional therapist, three activity staff, and four registered nurses) were able to describe how they incorporate resident choice into the residents activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with six relatives (one rest home, three hospital, one dementia unit and one psychogeriatric) and eight residents (five rest home and three hospital).
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	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents advance directive where applicable is on file. All files reviewed of residents in the secure units (three dementia and four psychogeriatric) had copies of the EPOA on file. The service has commenced a 'thinking about your loved ones quality of life' project. This project encourages and assists the registered nurses to have discussion with resident and family around advanced directives and resident and family expectations of care. Interviews with staff and families state they

give informed consent.		have input and are given choices. Care plans and 24 hour multidisciplinary care plans demonstrate resident choice as appropriate.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interview with relatives confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. Complaints forms are visible and available for relatives. A complaints procedure is provided within the information pack at entry. One complaint has been documented for 2016; this complaint has been logged onto the complaints register and had been responded to and managed appropriately with letters of acknowledgement and an investigation. An action plan has also been documented to ensure follow up. Management operate an "open door" policy.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Family members interviewed confirmed they received all the relevant information during admission.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Family interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection. Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings were documented in the eight resident files sampled.
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	Dementia Care NZ Ltd has a Maori health plan which has been recently reviewed, and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Maori have this recorded on file with an individual health care plan tailored to meet Maori cultural requirements. Linkages with Maori community groups are available and accessed as required such as Omaka Marae. There are four residents who identify as Maori. Two resident files reviewed for residents who identify as Maori had cultural linkages and whanau involvement in care planning.
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	The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident needs are being met. Discussion with family confirm values and beliefs are considered. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. Families interviewed spoke positively about these programmes. These provide information and support for family members in understanding dementia. Family/resident newsletters are provided quarterly and include an education component. Residents are supported to attend church services of their choice if appropriate.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual,	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals practice within their scope of practice. Interviews with registered nurses and care staff confirmed an awareness of professional boundaries.

financial, or other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Aberleigh Rest Home policies and procedures meet the health and disability service sector standards. An environment of open discussion is promoted. Staff report that the senior staff are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The registered nurses have access to external training. Discussions with family were positive about the care they receive. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. Four family members interviewed spoke very positively about the care provided and were well informed and supported. There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. Relatives interviewed stated they are notified promptly of any incidents/accidents. Evidence of communication with family/whanau is recorded on the family/whanau communication record, which is held in each resident's file. Families receive newsletters that keep them informed on facility matters and events. Incident and accident forms sampled and files reviewed evidence that family are notified following adverse events or when there is a change in resident's condition. Resident/family meetings encourage open discussion around the services provided There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Aberleigh Rest Home provides care for up to 62 residents across four service levels (hospital [medical and geriatric], rest home, psychogeriatric and dementia level care). One the day of audit, there were the 20 residents across the two 10-bed dementia units; five of six residents in the psychogeriatric unit (PG), and 15 hospital residents and 13 rest home level residents in the 36-bed dual purpose hospital/rest home wings. All residents were under an aged related contract. There were no respite residents. Aberleigh Rest Home is one of nine facilities operated by Dementia Care NZ Limited (DCNZ). The nine aged care facilities throughout NZ provide rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes two directors and a governance team of managers. A regional clinical manager for the South Island supports the management team at Aberleigh Rest Home. A

		business plan is in place for all facilities, covering the period July 2015 to June 2016. An operations manager and a clinical manager oversee Aberleigh Rest Home on a daily basis. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the regional clinical manager South Island who reports to the clinical director The operations manager has been in the role for two years. She has qualifications in management and dementia care. The clinical manager (registered nurse) is responsible for the clinical oversight of the service. The clinical manager has been in the role for four years. An organisational quality systems manager, a regional clinical manager, clinical director and an education coordinator also support the operations manager and clinical manager. The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the operations manager, the clinical nurse manager assumes the role with support from the DCNZ management team.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	CI	Aberleigh Rest Home is implementing a quality and risk management system. The organisation wide quality and risk operational plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement reports are provided to the monthly quality meeting. A number of meetings include discussion of quality data and follow through of quality improvements. The monthly staff bulletin also includes all quality data, incidents and accidents and infection rates. Discussions with staff confirmed their involvement in the quality programme. The internal audit schedule for 2016 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Benchmarking with other facilities occurs on

		data collected. Any areas of noncompliance from data generated through quality monitoring and reporting such as: audits, incidents and accidents, infection control are entered onto a central computer data base. The operation manager ensure that these are all followed up and signed off when completed Surveys are completed including (but not limited to) relatives (welfare guardians), and post admission surveys. Surveys reviewed included an analysis and QIs developed where needed. The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The clinical governance group develop and review policies and procedures. The service has a health and safety management system with designated staff representatives who have completed specific training. There are implemented risk management, and health and safety policies and procedures in place. There are identified goals as part of the annual health and safety plan. Progress to meeting these goals are reported to the monthly health and safety meetings. Falls prevention strategies are in place that includes assessment of risk, medication review, vitamin D, assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Accident/incident forms for June 2016 were sampled. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were also recorded in the resident progress notes. There is documented evidence the family had been notified promptly of accidents/incidents. The service collects incident and accident data and reports aggregated figures to the quality meetings, reported daily to the operations manager and reported weekly to the senior management team. Staff are informed via staff meetings and graphs are made available via the staff bulletin. Staff interviewed agreed they are well informed regarding incidents and accidents. Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource	FA	There are human resources policies to support recruitment practices. Ten staff files sampled (two registered nurses, four caregivers, one diversional therapist, one activities person, and two team leaders) contained all relevant employment documentation. Current practising certificates were sighted for the registered nurses

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		(RN) and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. There is an education planner in place that covers compulsory education requirements. The RN's have completed InterRAI training. Clinical staff complete competencies relevant to their role. There are 37 staff employed across the dementia unit and psychogeriatric units. Twenty-five have completed the required dementia unit standards. Ten caregivers are in the process of completing and all have been employed for less than 12 months (two staff have recently commenced at Aberleigh).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The operations manager and the clinical manager are on-site full time and available after hours. There is also a registered nurse on duty 24/7 in the dual service hospital/rest home unit There is no specific RN allocated to the six bed psychogeriatric unit as specified by the ARHSS contract, noting that occupancy at audit was 15 hospital and 5 psychogeriatric residents in total and the two wings are on the same floor and closely located. The dementia units and the PG units are managed on a day-to-day basis by home managers (senior caregivers). They are supported by the RNs on each shift in the hospital and clinical manager. The caregivers and family interviewed inform there are sufficient staff on duty at all times.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations or in locked draws. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.
Standard 1.3.1: Entry To	FA	There are pre-entry and admission procedures in place. Residents are assessed prior to entry by the needs assessment coordinators and where required the psychogeriatric team. The clinical manager liaises closely

Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		with the assessing teams to ensure the service can meet the assessed resident needs of the resident. The service has a comprehensive information booklet for residents/families at entry. It is designed so it can be read with ease (spaced and larger print). The service has developed a programme "sharing the journey" which is a family support group to assist relatives with coming to terms with a resident with advanced dementia and provides education, care and support for the family. The service also has a specific orientation programme for relatives who have family members being admitted to the rest home or hospital. Family members interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process. Admission agreements reviewed in eight files (two rest home, two hospital, three dementia and one psychogeriatric level of care) align with the ARRC and ARHSS contract. Admission agreements had been signed in a timely manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential aged care form that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Sixteen medication charts were reviewed (four rest home, four hospital, six dementia and two psychogeriatric). The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room and nurses' station. Medication administration practice complies with the medication management policy for the medication round sighted. Registered nurses only administer medications in the hospital and psychogeriatric units. Caregivers administer medications in the rest home and dementia care units. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery of the robotic packed medication and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. There is a monthly review of antipsychotic medication use. There were no residents self-administering medication on the day of audit. Standing orders were in use and the practices comply with all contractual and legal requirements.
Standard 1.3.13: Nutrition,	FA	There is a kitchen service manual located in the main kitchen, which covers all aspects of food preparation,

Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		kitchen management, food safety, kitchen cleaning, and kitchen procedures. All kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service training. Containers of food are transported in hot boxes to each area which all have kitchenettes, where caregivers plate and serve the meals. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available. There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. The dry good store has all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. There is evidence that there are additional nutritious snacks available over 24 hours for the dementia and psychogeriatric unit residents. Residents and the family members interviewed were very happy with the quality and variety of food served.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining service entry to residents is recorded should this occur and communicated to the resident (as appropriate)/family. The clinical manager reports that the referring agency would be advised when a resident is declined access to the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The information gathered at admission is used to develop care needs and supports to provide best care for the residents. Risk assessment tools are reviewed at least three monthly. InterRAI assessments have been completed for all residents and reviewed at least six monthly. The outcomes of interRAI assessments including the risk assessments were reflected in the long-term care plans reviewed. The diversional therapists and other activities staff completes a comprehensive social assessment and comprehensive activity care plan in consultation with the resident/family. One psychogeriatric resident file reviewed included an individual assessment that included identifying diversional, motivation, and recreational requirements.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The outcomes of InterRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. The care plans sampled included documented interventions to meet the resident's assessed care needs. Care plans demonstrate allied health input into the residents care and well-being. Family members interviewed confirmed they are involved in the care planning process. The one psychogeriatric resident file reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at handover (witnessed). If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. There were four wounds present on the day of audit. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. There is specialist input into the residents care in the psychogeriatric unit. The community mental health/psychiatric nurse visits at least two weekly and liaises closely with the clinical manager/RN, GP and the psycho-geriatrician based at Nelson. The community mental health/psychiatric nurse (interviewed) confirms the psycho-geriatrician is readily accessible. The psycho-geriatrician visits four to six weekly. There is evidence in the medical notes of GP communication with the psycho-geriatrician in regards to medication review. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment.
Standard 1.3.7: Planned Activities Where specified as part of	FA	A team of one diversional therapist (DT), and four DTs in training provide an activities programme for part of each day in each area. Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are resources available for staff for activities.

the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		The rest home and hospital programme is flexible to meet the needs of the residents and include (but not limited to); exercise, movements to music, word games, musical bingo, old time stories, newspaper reading, crafts, baking, happy hours, outdoor walks and pampering activities. The dementia programme is focused on household/meaningful tasks, reminiscing and sensory activities such as manicures and pampering activities, baking, garden walks, chats, music and sing-alongs, board games, café style afternoon teas, bowls and happy hours. Regular entertainment is scheduled. The DT oversees the activities in the psychogeriatric unit where the caregivers integrate activities into the daily activities for the small number of residents. The programme for the psychogeriatric residents is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities such as massage and foot spas, baking, garden walks, games music and movies RSA members visit regularly. Inter rest home activities and animal visits are enjoyed. There are weekly interdenominational church services and Sunday Catholic services/communion. Entertainment is regularly scheduled in each unit. Ethnic and cultural preferences are met as evidenced in the activity care plans sampled. There are van outings. The activities staff have a current first aid certificate. A comprehensive social history is completed on or soon after admission and information is gathered from the relative (and resident as able) and is included in the activity care plan. Activity assessments, activity plan, 24 hours multidisciplinary care plan progress notes and attendance charts are maintained. Resident and family meetings are held. Resident files reviewed identified that the individual activity plan and 24 hour multidisciplinary care plan is reviewed with the care plan review. Caregivers are observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions and dementia. Activities were observed to be occurring in the lounges during the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files sampled demonstrated that the long-term care plans were evaluated at least three monthly (or earlier if there was a change in health status) for hospital and psychogeriatric residents and at least six monthly (or earlier if there was a change in health status) for rest home and dementia care residents. There was at least a three monthly review by the GP. Overall changes in health status were documented and followed up. Reassessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is on-going, as sighted in resident files sampled. Where progress is different from expected, the service updated changes in the long-term care plan.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	There are three wings (Kowhai, Koromiko, and Totara) that provide rest home and hospital level care dual services for up to 36 residents. Kowhai and Koromiko have their own kitchenette and lounge dining areas and Totara has a dining area off the main kitchen and a separate TV lounge. There are two secure ten bed dementia units (Matai and Rata) that are joined by a connecting lockable door. Each of the secure dementia units have their own kitchenette and lounge dining areas. Ngaio is a secure six bed psychogeriatric unit that has its own kitchenette and lounge dining area. All areas have enough space and seating to provide for individual and group activities. The home has a current building warrant of fitness which expires on 1 July 2016. General maintenance is managed by the operations manager. There is a scheduled maintenance plan in place. Contractors are contacted when required. The service employs a building project manager to oversee the maintenance programme. The hot water temperatures exceeded 45 degrees in one resident area. Medical equipment has been checked and calibrated and testing and tagging of electrical equipment has been conducted. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors from

		each facility. The interior courtyards and gardens are well maintained with safe paving, outdoor shaded seating, lawn and gardens. The residents in the dementia and psychogeriatric units can access secure outdoor areas. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Most rooms have ensuites and some bedrooms have shared ensuites. Other residents share communal toilets and showers. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and	FA	There are large communal lounges and dining areas in each wing. There are also smaller sitting areas for residents and families to access. Communal areas in each unit are used for activities, recreation and dining activities. All dining rooms are spacious, and located directly off the kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.

dining needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All linen and personal clothing is laundered on site. Adequate linen supplies were sighted. The cleaning cupboard containing chemicals is locked. All chemicals have manufacturer labels. The cleaning trolley is well equipped and stored in a locked area when not in use. Staff cleaning were observed to be wearing appropriate personal protective equipment. The resident environment on the day of audit was clean and tidy in all areas. The residents interviewed were satisfied with the cleanliness of the communal areas and their bedrooms.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.
Standard 3.1: Infection control management	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the infection control team. Meeting are monthly

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.		and minutes are available for staff. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection programme is reviewed annually at an organisational level and is linked into the objectives of the quality and risk management plan. The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level. The facility has access to professional advice within the organisation, from GPs and from Southern Community Laboratories. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The designated infection control (IC) coordinator is an RN. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. IC committee is made up of a cross section of staff from across the service. The IC nurse has support from the organisation staff trainer, and she has completed external training.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the	FA	There is an infection control manual which includes policies and procedures appropriate to for the size and complexity of the service. There are policies and procedures that include (but are not limited to); a) infection control nurse responsibilities, b) antimicrobial usage, c) infection control including renovations and construction, d) accidental exposure to blood, e) healthcare waste, f) definitions of infections, and g) outbreak management. Any changes or updates to the infection control policies are notified at the staff and quality meetings and are recorded in the staff bulletin.

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand competencies including hygiene competency. The IC coordinator (registered nurse) has completed external training. Staff receive infection control on orientation and annual infection prevention and control education.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms and short term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control co-ordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, Infection control and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. The service has four residents with restraint these include; one hospital resident with a lap belt restraint and one hospital, one dementia and one psychogeriatric resident with a T belt restraint. The PG resident has not used this restraint for some time and is currently being reviewed to remove the restraint completely. All enabler use is voluntary, there are no resident with enablers.

Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator is a registered nurse. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. Assessments are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint assessment form is completed with input from the RN, and GP and the resident's family and this was documented in three resident's files for residents who use restraint. Three resident files were reviewed for restraint process and use (two hospital and one dementia). All three had documented assessments, consents and care plan interventions.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Three files were reviewed for residents with restraint. The review identified clear instructions for use of the lap belt/ T belt, approval process, risks and monitoring requirements. Restraint monitoring records are completed by staff. The restraint register is in place and is up to date
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Three files were reviewed of residents requiring restraint. The use of restraint episodes are evaluated three monthly as part of the GP review. All episodes of restraint are also monitored monthly through the RN meeting. A six monthly resident minimisation group reviews all episodes of restraint use and a report is provided to the service and senior teams.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint coordinator is a registered nurse. The restraint minimisation committee at meet six monthly to review restraint use. An annual audit is completed on restraint use. Monthly reviews as part of the registered nurse meeting are well documented.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	There is a documented staffing rational and policy in place. Rosters are published for staff. Residents and family interviewed praised the staff and the level of staffing. The PG unit does not have an allocated registered nurse rostered over a 24 hour period.	There is no specific RN allocated to the six bed PG unit 24 hours a day as specified by the ARHSS contract D17.3b.	Ensure staffing meets the ARHSS contract D17.3b for the PG unit. 60 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery	PA Low	The general practitioners (GPs) review newly admitted residents within two working days. Residents are reviewed three monthly or earlier by GPs if they are not medically stable. Fifteen GP’s provide services at Aberleigh Rest Home. A GP visits the facility each week and they are on call if needed. Registered nurses can initiate urgent	One rest home resident newly commenced on insulin; was noted in the progress notes by a registered nurse to have had a hyperglycaemic episode overnight. This was followed up by the RN and managed appropriately as documented on the	Ensure that all residents with an acute change in health condition have the follow up assessment/management documented in the progress notes.

and promotes a team approach where appropriate.		admissions to the DHB if necessary and can consult with other health professionals operating in the area. A medical officer interviewed spoke very highly of the care provided by staff. A physiotherapist is contracted to visit weekly to assess any new residents, attend the six monthly reviews (as relevant) and follow-up any resident concerns such as post fall assessments. The podiatrist visits regularly. A dietitian is available and is involved in resident reviews where applicable and is readily available to the clinical and food services team for any advice or resources. Allied health professionals record visits in the integrated notes. There is close liaison and communication with the mental health services for the older person, psychogeriatric community nurse, GPs and their practice nurses and hospice services. The registered nurse is responsible for the nursing assessment of all residents. There was one file reviewed where the progress notes did not reflect the follow up actions taken by staff.	handover notes between shifts. However, management of this event was not documented in the progress notes.	90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Hot water temperatures checks are conducted weekly. There was evidence of hot water temperatures in excess of 45 degrees in one room in Matai wing over the past six months. The facility advised that a plumber has been consulted about this; however the problem has not yet been fixed.	Eighteen incidents of hot water temperatures in excess of 45 degrees (ranging from 47-52 degrees) were noted for one room in a resident area in Matai wing since December 2015.	Ensure that hot water temperatures do not exceed 45 degrees in resident areas. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	CI	Copies of the residents advance directive where applicable is on file. The service has commenced a ‘thinking about your loved ones quality of life’ project. This project encourages and assists the registered nurses to have discussion with resident and family around advanced directives and resident and family expectations of care	Dementia Care NZ had identified that current advanced care planning documentation did not meet the needs of residents who were not cognitively competent to contribute to their end of life plans. A document called ‘thinking about your loved ones quality of life ’ was developed by DCNZ. The document was also designed to show a language that our team of young registered nurses could use to develop their skills when needing to have a critical end of life conversation. This document assist registered staff to assist families to consider the current health and prognosis of their loved one. The document then allows the family to consider any thoughts expressed by their loved one in regard to the last days of their life. The feedback indicated that the registered nurse staff had greater clarity around the end of life wishes for their residents. Conversations although difficult at times have provided certainty in regards to family and resident

			having full understanding of their services and options available at end of life.
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Services are provided at Aberleigh Rest Home that adhere to the health and disability services standards. There are well-developed manuals for all areas of the service. Dementia Care NZ has developed a Clinical Governance group to provide excellence in clinical practice. The group has specific terms of reference and includes senior management staff from the organisation and from each of the nine Dementia Care NZ homes, as well as external clinical experts. Projects and improvement outcomes are shared with all facilities to mitigate risk and to ensure that clinical excellence is maintained. Individual homes such as Aberleigh Rest Home also develop quality and clinical improvement projects.	The DCNZ Clinical Governance group was set up in 2014 in response to growth within the organisation and a need to ensure that clinical excellence was maintained throughout each of the nine homes owned by Dementia Care NZ. The organisational response to the increase in registered nurses employed as a result of the company growth, was to develop the Clinical Governance group. Terms of reference for the group are documented and include providing strategic clinical leadership and direction. The group comprises the director of Dementia Care NZ, the clinical director, the two regional clinical managers (north and south), and the group educator. Monthly meetings are held to conduct analysis of clinical quality indicators, development and endorsement of clinical quality activities, policy development and review, case studies, education for clinical managers including post graduate study, and sharing of information with the clinical teams. Projects have been identified as a result of the collation of the clinical data and include: falls prevention/reduction benchmarking of urinary tract infections (UTI); a wound and skin integrity project; an End of life care project; and professional development pathways for clinical managers and registered nurses. These project are all in the process of implementation at Aberleigh. The effectiveness of the Clinical Governance group is continually evaluated through meeting minutes, review of projects and outcomes, sharing of information between facilities, staff surveys, family surveys, retention of staff, engaging of external clinical experts for objective opinions and views, review of benchmarking clinical indicators and review of the outcomes of continuous quality improvement projects
Criterion 1.2.3.1	CI	Aberleigh Rest Home is implementing a quality and risk management system. The	The quality programme is reviewed regularly to assess achievements with set targets.

The organisation has a quality and risk management system which is understood and implemented by service providers.		organisation wide quality and risk operational plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data.	The quality and risk management team for Aberleigh meets monthly to review the quality and risk management plan and goals, and to receive a comprehensive quality report. Benchmarking with other Dementia Care NZ facilities with rest home dementia and psychogeriatric level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents, complaints) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. Complaints data collated for 2015 and 2016 provides evidence of the achievement towards the set goals within the quality and risk operation plan. Complaints rates at Aberleigh are at the lowest rate for the group. The satisfaction survey for 2015 recorded that all respondents who raised complaints in the previous year felt their complaints were managed appropriately would recommend the service to family and friends
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	A falls reduction/prevention project has been identified as a group wide initiative and is being implemented at Aberleigh. The aim of the project is to minimise fall incidents in each facility. The rate of falls within each unit is gathered monthly, as part of benchmarking clinical indicator data. A falls coordinator (registered nurse) has been appointed at Aberleigh.	The falls reduction project implemented at Aberleigh has included: i) Using a falls map and other validated falls assessment tools. A white board communication system for falls mapping has been set up in the nurses' station, to identify when and where falls have occurred. This is to increase vigilance with resident supervision and provides a visual reference for caregivers. ii) The falls coordinator has facilitated and coordinated education to staff (March 2016) and a falls competency package is part of staff competencies. This has been provided to increase staff awareness around falls minimisation. iii) A register of residents on vitamin D has been set up and is updated monthly. iv) Falls prevention policies and procedures have been developed/reviewed. v) Antipsychotic medication use is monitored, with inappropriate prescribing or negative effects mitigated or reduced.

			The outcomes of the falls minimisation project at Aberleigh has resulted in a review of the benchmarking data and calculation method used in smaller units that have less than 22 beds as currently one fall places the smaller unit over the benchmark NZ indicator for safe aged care
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	The service has identified training and education for staff as a quality and risk operation plan goal. An education officer (registered nurse) is employed by Dementia Care NZ to facilitate the education programme for all sites. The education programme includes a comprehensive orientation programme for new staff. The half-day session includes introduction of key staff, infection control, restraint minimisation and clinical care. The education programme is supported with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, infection control, safe chemical handling, health and safety, abuse and neglect and restraint. All care staff are supported to complete first aid qualifications and the ACE programme, including dementia unit standards. .	The annual education programme is comprehensive and includes programmes designed and implemented by the service. The "best friends approach to care" programme is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff. This is based on the service’s vision, values and philosophy. A monthly evaluation of incident reports including ‘behaviours that challenge’ identifies good use of de-escalation techniques. Education around behavioural and psychological symptoms of dementia,. Non-violent crisis intervention training and intercultural awareness training is ongoing at Aberleigh. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. The effectiveness of the education programme is evidenced by positive feedback from family surveys that show high satisfaction with the clinical care provided. Staff interviewed advised that they receive valuable support and education around the management of challenging behaviours and were conversant with the ‘best friends’ approach to resident cares. Professional development training for clinical managers is provided with a group wide forum held twice yearly (last conducted in March 2016). The Aberleigh Clinical Manager has participated in the twice yearly DCNZ Clinical Manager education days. During this time she has presented and developed a package of learning to be used as a resource for the DCNZ Registered Nurse team.

End of the report.