

# Marton Edale Home Trust Board - Marton Edale Home

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## Introduction

This report records the results of a Certification Audit; Partial 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 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:** Marton Edale Home Trust Board

**Premises audited:** Marton Edale Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 18 July 2016 End date: 19 July 2016

**Proposed changes to current services (if any):** A partial provisional audit was conducted to assess the preparedness of the service to provide hospital level of care. Reconfiguration of the 30 beds (currently 23 rest home and seven dementia care) to provide 15 dual-purpose beds, eight rest home beds and seven dementia level of care beds. One wing of six dual-purpose beds and renovated toilet/showers has been assessed as ready to be occupied for use following the purchase of a showering equipment and recruitment of 24-hour RN.

**Total beds occupied across all premises included in the audit on the first day of the audit: 25**

# 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

Marton Edale rest home is a not-for-profit organisation governed by a board of trustees. Marton Edale provides rest home and dementia level of care for up to 30 residents. On the day of the audit, there were 25 residents.

This certification audit was conducted against the relevant 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 resident and staff files, observations, and interviews with family, residents, management, staff and the general practitioner.

The business manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse) who oversees the clinical services. There are quality systems and processes being implemented. The residents and relatives spoke very positively about the care and services provided at Marton Edale.

There were no areas for improvement identified as part of the certification audit.

A partial provisional audit was also conducted to assess the preparedness of the service to provide hospital level of care. This audit verified there are appropriate processes being implemented for providing rest home, dementia and hospital level of care. Required improvements identified from this audit relate to completion of the renovations and purchasing of specialised equipment, and recruitment of registered nurses to provide 24-hour cover.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Marton Edale rest home and dementia care has implemented a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards. Monthly quality data reports are discussed at facility meetings. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of

rest home and dementia care. An implemented orientation programme provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The service has a well-developed assessment process and all residents have an InterRAI LTFC assessment undertaken within three weeks of admission and six monthly or sooner. The clinical manager (registered nurse) and the registered nurse complete assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented, and used to assess the level of risk and support required for residents. Care plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access with other medical and non-medical services.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The service medication management system follows recognised standards and guidelines for safe medicine management practice. Staff responsible for administering medications complete annual competency assessments. The services use an electronic medication system.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food provided. Nutritious snacks are provided 24-hours.

## 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.
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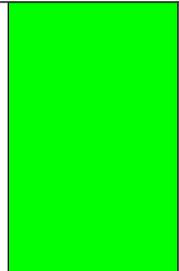
Chemical safety is maintained. The proposed dual-purpose rooms, lounges and dining areas are suitable for providing hospital level care. There is adequate equipment provided to ensure the needs of residents are met. The building holds a current warrant of fitness. A maintenance prevention programme is implemented. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. There is a plentiful supply of protective equipment, gloves, and aprons. Appropriate training, information, and equipment for responding to emergencies is provided. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate. There is an approved evacuation plan.

## 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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There are policies and procedures to follow in the event that restraint or enablers are required. There were no residents using enablers or with restraint in place. The clinical manager is the restraint coordinator. Staff receive annual training around restraint and challenging behaviours.

## 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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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	43	0	2	0	0	0
<b>Criteria</b>	0	91	0	2	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)
<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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Six rest home residents and four relatives (three of rest home and one dementia level of care) interviewed, confirmed that information has been provided around the code of rights. Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Staff attend Code of Rights training. Discussion with four healthcare assistants (HCA), three who work in the rest home and one from the dementia care unit, identified they were aware of the code of rights and could describe the key principles of resident's rights when delivering care.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There is evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.  Five of five resident files sampled (three from the rest home and two from the dementia unit) have a signed admission agreement and consents.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Pamphlets on advocacy services are available at the entrances to both the rest home and hospital buildings. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services. The Whanganui health and disability advocate visits the service to meet with families as required and provides staff training on the role of advocacy services. The service also has links with age concern.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. All residents interviewed confirmed that family and friends are able to visit at any time and visitors were observed attending the home. Residents and relatives verified that they have been supported and encouraged to remain involved in the community where appropriate. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme. The service uses a community bus with wheelchair access for outings.</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 complaints procedure is provided to residents and relatives at entry to the service. The business manager who is the privacy officer, has completed a privacy and confidentiality training day. The business manager maintains a record of all complaints, both verbal and written by using a complaints register. There have been no complaints made in 2015. One complaint received by the DHB to date for 2016 has been fully investigated and found to be unsubstantiated. The complaint was managed in line with Right 10 of the Code. Residents and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The code of rights and advocacy brochures are displayed and there is a welcome information folder that includes information about the code of rights. The resident, family or legal representative has the opportunity to discuss this prior to entry and/or at admission with the business manager or clinical manager. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</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>	FA	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Care staff interviewed were able to describe how they maintain resident privacy. Staff attend privacy and dignity and abuse and neglect in-service as part of their education plan. Care staff interviewed state they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives.</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>	FA	<p>There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. The Māori health plan identifies the importance of whānau. Assessments plans for Māori are completed and reviewed in the files of residents who identify with Māori. The clinical manager and HCAs were able to describe how to access information and provide culturally safe care for Māori.</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>	FA	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to attend church services of their choice and are supported to attend other community groups as desired.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of a service code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with HCAs could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. Relatives interviewed stated staff are kind and respectful towards their loved ones.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>Management are committed to providing a service of a high standards, based on the trust's vision for provision of care. This was observed during the day with the staff demonstrating a caring attitude to the</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Registered nurses and HCAs have access to internal and external education opportunities. Staff have a sound understanding of principles of aged care and state that they feel supported by management. Facility meetings and clinical meetings enhance communication between the teams and provided consistency of care.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Management promote an open door policy. Relatives/residents are aware of the open door policy and confirm on interview that the staff and management are approachable and available. Residents have the opportunity to feedback on service delivery through resident meetings held three monthly. An annual relative meeting (of rest home and dementia care residents) held April 2016, documented discussion around the May 2016 survey results and business goals including the provision of hospital level of care. Resident meetings are open to families to attend. Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed state they are notified promptly of any changes to resident's health status.</p> <p>The service keeps the community informed on events with regular articles in the local community paper. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The home currently provides rest home care for up to 23 residents and dementia care for up to seven residents. On the day of audit, there were 19 rest home residents and six dementia level of care residents. All residents were under the ARCC. There were no residents on respite care or under 65 years of age.</p> <p>A Trust board of 13 community volunteers including representation from churches, service and voluntary agencies governs Marton Edale home. The board meets two monthly and oversees the financial budget. The management committee provides business and clinical governance. The chair of the board (interviewed) confirmed the committee receives monthly reports from the business manager and clinical manager. The chair of the board meets with the business manager weekly.</p> <p>The business manager (non-clinical) has been in the role for four years. She has previous business management experienced and involvement in the aged care sector. A fulltime clinical manager who has been registered in New Zealand for four and a half years supports the business manager. The clinical manager has been in the role for three years. A board member, who is a practicing RN at the DHB, provides clinical supervision for the clinical manager. The managers are supported to attend</p>

		<p>external training and have both completed at least eight hours of professional development relating to managing an aged care facility.</p> <p>The management and board have reviewed the 2015 business plan annually, in May. The Edale Trust Board strategic plan for 2016 to 2021 includes key objectives, accountability and timeframes for goals relating to governance, employment, service delivery and property development. The Edale vision and values have been included in the strategic business plan.</p> <p>Partial Provisional: The strategic business plan documents action plans and timeframes around the provision of hospital services. These include funding, building and equipment plans and recruitment processes. To date, six dual-purpose rooms have been renovated with another nine dual-purpose rooms due for completion by January 2017 (link 1.4.2.1). The community have been active in fundraising to support the building works.</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>Certification and partial provisional audit: During the temporary absence of the business manager, the clinical manager provides clinical and management oversight of the facility including the on-call requirement. The clinical manager is supported by the clinical governance/RN on the board. The service employs a part-time RN to cover the clinical manager's leave.</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 improvement principles.</p>	<p>FA</p>	<p>The service has a quality risk management plan in place that has been reviewed. An external consultant has developed a range of policies and procedures to support service delivery and they are reviewed regularly by the service. Policies reviewed are relevant to the provision of rest home, dementia and hospital level care. Infection control, health and safety, management and general staff meetings are held monthly. Discussion occurs around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Meeting minutes and quality data is available for staff.</p> <p>Internal audits are completed as scheduled and include environmental, infection control, organisational and clinical audits including monthly medication audits. Corrective actions are implemented for any audit results less than 90%. An annual resident/relative survey scored 89% to 97% across all services.</p> <p>The health and safety coordinator is a senior HCA who has completed health and safety stages one,</p>

		<p>two and three and has attended transition training in July 2016. The health and safety committee are representatives from across the services and meet monthly to review accidents/incidents and hazards. Contractors on site have all completed health and safety inductions. Relatives were informed at a recent meeting about the changes in the health and safety legislation.</p> <p>Falls prevention strategies are in place that includes the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The accident/incident policy is part of risk management and the health and safety framework. Accident/incident data and trends are collated monthly. Corrective actions are documented on the accident/incidents forms and in the monthly report.</p> <p>Twelve incident forms (ten rest home and two dementia care) were reviewed from June 2016. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. There was documented evidence of the on-call RN attending resident incidents after-hours. The healthcare assistants interviewed could discuss the incident reporting process.</p> <p>The business manager could describe situations that would require reporting to relevant authorities. There have been four notifications to the DHB and HealthCERT since May 2015 including two medication error reports. There have been no outbreaks.</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>	FA	<p>There are human resource policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Seven staff files were reviewed (clinical manager, RN, two HCAs, one health and safety coordinator/HCA, one diversional therapist and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. A comprehensive orientation programme provides new staff with relevant information for safe work practice. Healthcare assistants interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. New staff work the same roster as their mentor during and after orientation, to provide support as required, based on the individual progress of the new employee.</p> <p>Healthcare assistants commence Careerforce qualifications following appointment and are supported by the clinical manager who is a Careerforce assessor/verifier.</p> <p>Registered nurses are supported to attend external education. The clinical manager and RN have completed the InterRAI training. Staff complete competencies relevant to their roles. The annual education plan covers the required mandatory training requirements. Nine of nine staff who work in the dementia unit have completed the dementia unit standards. All HCAs have completed level three of the</p>

		<p>Careerforce qualifications.</p> <p>Partial provisional:</p> <p>Fourteen of sixteen HCAs have complete level four of the Careerforce qualifications in health and well-being within the last six months. The modules cover chronic illnesses, palliative care, skin assessments, and pressure injury prevention and other topics relevant to the provision of hospital level care. The clinical manager is a member of the regional palliative care resource group. Healthcare assistants have attended the fundamentals of palliative care with 65% of HCAs completing the course while others are still progressing through the modules. Newly appointed staff will complete the comprehensive orientation package one week prior to commencing clinical duties. The clinical manager and part-time RN will provide mentoring and support for newly appointed RNs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Low	<p>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The business manager and the clinical manager/RN are on duty during the day Monday to Friday. The clinical manager and part-time RN provide the on-call requirement for clinical concerns. Residents and relatives state there were adequate staff on duty at all times. Staff state they feel supported by management who respond quickly to afterhours calls.</p> <p>There is a diversional therapist (rest home) and activity officer (dementia care unit) on duty Monday to Friday. There is a dedicated laundry/cleaning person seven days a week.</p> <p>Partial provisional:</p> <p>A proposed roster for the addition of hospital level care residents was reviewed. There will be a minimum of one registered nurse rostered on each shift. There is scope within the proposed roster to increase healthcare assistant duties and roles in response to admission of hospital level residents. The service has yet to recruit sufficient registered nurses to cover the proposed roster. The activity hours will increase to cover seven days and an existing activity person returning from leave will cover this.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>

accessible when required.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager or clinical manager. The admission agreement form in use aligns with the requirements of the ARCC. Exclusions from the service are included in the admission agreement and information includes examples of how services can be accessed that are not included in the agreement. Five resident files reviewed (three rest home and two dementia care) had signed admission agreements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. Records are kept with the resident's file. All relevant information is documented and is communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Communication with the family is made and this is documented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Certification: There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses four weekly medico packs and has recently moved to an electronic system for the charting and administration of medications.</p> <p>The RN checks blister pack medications on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely in both the dementia unit and the rest home. RNs or senior caregivers administer the medication in both areas. Annual medication competencies are completed and education has been completed. Additional training was provided following two medication errors. The pharmacist completed education around medication safety. All staff were required to complete a further competency around administration of medication. Discussion around medications and errors are evidenced in staff meeting minutes. The weekly audit of administration of medications is evidencing accurate medication administration. Accident/incident forms were sighted for the two medication errors. The GP was notified and the next of kin. Critical incident reporting was completed to the DHB and HealthCERT (notifications sighted). Corrective actions and recommendations have been implemented and there have been no further medication errors.</p> <p>The clinical manager and RN have completed syringe driver training. Allergies are identified on the medication record. The clinical manager advised there were no residents self-medicating on the day of audit.</p>

		<p>Staff were observed on three medication rounds correctly using the electronic administration and recording system. There were no expired medications in the medication cupboards, trolley or fridges. Medication fridge temperatures are monitored (records sighted). Eye drops and ointments were dated on opening. Emergency oxygen and suction is available.</p> <p>Ten medication charts reviewed, (four dementia residents, six rest home residents), were fully compliant with requirements and guidelines.</p> <p>Partial provisional: There is an established medicines management system in place. There are policies and procedures in place for safe medicine management that meet legislative requirements. There is a dedicated medicine room and medicines trolley for use for rest home and hospital residents and another for dementia residents. The existing system will be capable of accommodating the addition of residents requiring hospital level care.</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>Certification: All meals at Edale are prepared and cooked on site. Two cooks manage the service. Both have completed food safety training. Kitchen hands hold food safety units with the exception of two kitchen hands undergoing orientation – they have received food safety education as part of their induction. All residents have a nutritional profile developed on admission which is reviewed six monthly. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. The four weekly rotating summer/winter menu is designed and reviewed by a registered dietitian (October 2015). The dietitian reviewed the menu in April 2016 to ensure modified diets were included in the menu plan for hospital level residents. Residents requiring extra assistance to eat and drink are helped by healthcare assistants and were observed receiving help.</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving and all meals are plated in the kitchen.</p> <p>There is evidence of additional nutritious snacks being available over 24-hours.</p> <p>Upgrading in the kitchen is planned, including the replacement of shelving with stainless steel shelves and new chiller and freezer units.</p> <p>Residents commented positively on the meals provided and have the opportunity to feedback on the service directly to cooks and through resident's meetings and surveys.</p> <p>Partial provisional: There is an established system in place, which will be able to accommodate the change in service level. Equipment to assist residents was also available. There is an area in the dining room that can be screened discreetly, to maintain the dignity of hospital level residents requiring feeding. The kitchen, kitchen equipment and kitchen staff are able to meet the needs of hospital level residents including the provision of altered texture meals and varying dietary requirements.</p>

<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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>	FA	<p>The service records the reason for declining service entry to residents, should this occur, and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. InterRAI assessments, including risk assessments, are completed on admission and reviewed at least six monthly or if there is a change in the resident's condition. The outcomes of assessments were reflected in the long-term care plans in resident files reviewed.</p>
<p><b>Standard 1.3.5: Planning</b></p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans sampled document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and demonstrate input from allied health. Care plans for dementia care residents included emotional care and behaviour management triggers, interventions and de-escalation strategies including activities. Short-term care plans are in use for changes in health status.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation reviewed and interviews with staff, residents and relatives identified that care is being provided consistent with the needs of residents. There is evidence that families are notified of any changes to their relative's health including (but not limited to) accidents/incidents, infections, health professional visits and changes in medications. Monitoring charts and behaviour monitoring charts were sighted in files sampled.</p> <p>Dressing supplies are available and a treatment room/cupboard is stocked for use. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds - two non-healing conditions, two skin tears and a pressure injury. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. The clinical manager and registered nurse interviewed described the</p>

		<p>process, should they require assistance from a wound specialist.</p> <p>Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status.</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>A qualified diversional therapist provides activities in the rest home and an activities coordinator provides activities in the dementia unit across five days. The activity coordinator is working towards a diversional therapy qualification.</p> <p>On the day of audit, residents were observed actively involved with a variety of activities in the rest home and the dementia unit. The programme is developed weekly and is displayed in the rest home foyer and in the dementia unit, it is displayed daily on a large notice board. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and in the dementia unit, this is used to write an emotional plan (Spark of Life programme).</p> <p>The programme observed in the dementia unit was appropriate for older people with cognition and memory impairments. The programme was meaningful and reflected ordinary patterns of life. A plan of activities for weekends is left for carers to undertake. There are visits from community groups and regular volunteers.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme, to the activity staff through three monthly resident meetings or following activities. There are regular outings. Resident files reviewed identified that the individual activity plan is reviewed six monthly. Attendance records are maintained and graphed for analysis.</p> <p>The activities programme is able to cater for the needs of hospital level residents.</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>Care plans reviewed had been evaluated by a registered nurse six monthly or when changes to care occurred. There was documented evidence of care plans being updated as required.</p> <p>There is at least a three monthly review by the medical practitioner and weekly by the mental health unit for the residents under the care of the psychogeriatrician.</p> <p>Short-term care plans are reviewed regularly, and if there is an ongoing problem, resolved or transferred to the long-term care plan.</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>Discussions with the clinical manager and registered nurse identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled.</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>There are implemented policies in place to guide staff in waste management. The 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. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data and product use sheets were available. Staff had completed chemical safety training.</p> <p>Partial Provisional: There will be no changes to the existing waste management system, which will be able to accommodate hospital level care. The renovation of the existing sluice room has not been fully completed (link 1.4.2.1).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building has a current building warrant of fitness that expires on 1 July 2017. There is a contracted maintenance person who works regular hours and is available on call if needed. There is a gardener. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged and clinical equipment has had functional checks/calibration undertaken annually. Hot water temperatures have been tested and recorded with corrective actions for temperatures outside of acceptable range.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. The corridors are wide with handrails.</p> <p>The secure dementia unit has a lounge and dining area, which was well supervised on the days of audit. One bedroom is used for day care residents and a quiet lounge. A secure outside/garden area contains raised garden beds for use by the residents who enjoy gardening.</p> <p>The external areas are well maintained and there is safe access to the outdoor areas. There is outdoor seating and shade.</p>

		<p>Partial Provisional:</p> <p>Healthcare assistants interviewed stated they had adequate equipment for the safe delivery of care including two sling hoists. New wheel-on weigh scales have been purchased as well as two air alternating pressure prevention mattresses. The service has purchased electric beds with high-pressure rating mattresses, hospital level lazy boy chairs on wheels and a new standing hoist. Fundraising is underway to purchase two ceiling hoists. Specialised showering equipment has yet to be purchased.</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 sufficient communal toilets and showers to cater for residents in the rest home and dementia unit. Communal toilet facilities have a system that indicates if it is engaged or vacant. All bedrooms have a hand basin.</p> <p>Partial Provisional: The toilets and showers in the dual-purpose wings are of a size to accommodate equipment that may be needed for hospital level residents. Two toilet/shower rooms in the renovated six-bed wing have been fully renovated and has non-slip flooring. The remaining two toilet/shower rooms for dual-purpose are of sufficient size and meet the requirements and will undergo renovation as part of the overall plan. All bedrooms have a hand basin.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single. Residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids for residents at rest home and dementia level of care. Residents are encouraged to personalise their bedrooms.</p> <p>Partial provisional: There are 15 bedrooms to be renovated and upgraded for dual-purpose. One wing of six bedrooms has been completed and is spacious enough for the delivery of hospital level of care. Renovation of the other nine dual-purpose rooms is ongoing and the expected time of completion is January 2017 (link 1.4.2.1). Following renovations, the reconfiguration of rooms will be eight rest home beds (rooms 27 to 34), 15 dual-purpose (rest home/hospital) and seven dementia care beds. The completed dual-purpose rooms viewed have widened doors and new vinyl flooring has been laid.</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</p>	FA	<p>The communal areas in the rest home include the main lounge and dining areas along with a separate family lounge and a large sunroom. The communal areas are easily and safely accessible for residents. The dementia unit is currently secure within the existing structure. An existing dementia bedroom is currently being used as a lounge. The building plan includes a quiet lounge in the dementia unit and relocation of the secure doors. One existing rest home bed will become the quiet lounge for the dementia unit, with entry into the lounge from within the dementia unit. The secure doors will be</p>

<p>their relaxation, activity, and dining needs.</p>		<p>relocated back to the reconfigured entrance of the dementia unit. Renovations are in progress.</p> <p>Partial Provisional: The main lounge and dining area in the facility is spacious enough to accommodate residents at hospital level care. A spacious separate sunroom can be used as a second lounge for quiet activities. The smaller lounge will be converted into a spacious dual-purpose 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>Certification: Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done on-site in the well-equipped laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p> <p>Partial provisional: There will be no change to existing laundry and housekeeping processes and staffing. Current systems will be able to cater for the addition of hospital level residents.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available, within the rest home and dementia care units. The kitchen has power and gas cooking and there is a gas barbeque and gas bottles available. There is sufficient water and food stored on-site for at least three days in the event of an emergency. A generator is provided through a local company as required.</p> <p>There is an approved fire evacuation scheme in place dated 3 July 2009. There are six monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with afterhour's doorbell access, which is connected to the call bell system. The dementia unit has secure entry and exit.</p> <p>Partial provisional: There has been no addition of beds or building extensions or modifications that would alter the staged evacuation plan. There has been consultation with the fire service and contractors during the renovation. One fire exit with ramp access has been developed. The existing call system is appropriate for hospital level care. There is no change required to the existing emergency management plans.</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>All bedrooms and communal rooms including those to be used for dual-purpose have an opening window to the outside. Heat can be controlled in individual rooms.</p> <p>Partial provisional: Improved lighting and night lights have been installed in the renovated dual purpose rooms.</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>Certification audit: The clinical manager has been in the role of infection control coordinator since 2012 and has a defined job description. The infection control coordinator is responsible for the collation of infection events and reporting to the infection control committee and monthly to the business manager and board of trustee's management committee. The 2015 infection control programme has been reviewed in May 2016 and linked to the quality system.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine.</p> <p>Partial Provisional: The infection control team consists of the business manager, the clinical manager and care staff. The infection control team will remain in place with the change in service levels and remains appropriate to the size and scope of the service provided.</p>
<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>The infection control coordinator has attended annual external infection control education including outbreak management. The infection control committee is representative of services and meets monthly for the review of infection data, training, internal audits and other infection control topics.</p> <p>The infection control coordinator has access to GPs, laboratory service, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed by an external consultant and are reviewed</p>

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.		regularly.
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. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and annually in February of each year. Staff complete infection control questionnaires.  Resident education is expected to occur as part of providing daily cares as appropriate.
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	There is a policy describing surveillance methodology for monitoring of infections. ,The infection control coordinator collates information obtained through surveillance, to determine infection control activities and education needs in the facility. Infection control data and relevant information is communicated to staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the infection control committee meetings and general staff meetings. Monthly infection control reports are provided. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.  There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The clinical manager is the restraint coordinator with defined responsibilities. The restraint team meet six monthly to review enabler/restraint use. Currently there are no residents with enablers or restraints. Restraint and challenging behaviour education is included in the training programme. Staff receive education on enablers/restraint during orientation and complete competency assessments.

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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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>A draft roster provides 24-hour RN nursing cover and adequate HCA hours for hospital level of care. The board has approved the roster. The service will require four RNs (each working 32 hours per week) to provide 24-hour RN cover. The clinical manager is full-time and the part-time RN will increase to six hours per day Monday to Friday. The clinical manager has received applications from RNs interested in working at Edale. The chair of the board (interviewed) stated the board support new staff coming into the area and provide flat accommodation located on-site.</p>	<p>Registered nurses have not yet been recruited to provide 24-hour RN cover for hospital level of care.</p>	<p>Ensure there is a RN on duty at all times.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings,</p>	PA Low	<p>There is sufficient equipment available for hospital level of care residents that includes beds, lounge chairs and transferring equipment. Specialised showering equipment</p>	<p>i) Specialised showering equipment is not yet available for use with</p>	<p>i) Ensure hospital level showering equipment, such as a tilting shower chair or</p>

<p>plant, and equipment comply with legislation.</p>		<p>is not yet available. There is a sluice room within one of the dual-purpose wings that has been upgraded for hospital level of care however this is not ready for use. Six dual-purpose rooms and two toilet/shower rooms have been renovated ready for use. There are nine dual-purpose rooms to be completed as planned. The full renovation is expected to be completed January 2017.</p>	<p>hospital level residents. ii) The service has purchased a sanitiser but it is yet to be installed. iii) The renovation of nine dual-purpose rooms is incomplete and therefore are unable to accommodate hospital level residents.</p>	<p>shower trolley is available for use. ii) Ensure the sanitiser is installed ready for use. iii) Ensure that all renovations are completed and that rooms are of sufficient size to accommodate hospital level residents.</p> <p>Prior to occupancy 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.