

Athenree Lifecare (2016) Limited - Athenree Rest Home

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Athenree Lifecare (2016) Limited |
| Premises audited: | Athenree Rest Home |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 21 July 2016 End date: 22 July 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: | 33 |

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.

General overview of the audit

Athenree Lifecare provides rest home, dementia, hospital (medical and geriatric) services for up to 43 residents at its facility in Athenree in the Bay of Plenty. It is owned and operated by Heritage Lifecare Limited.

This provisional audit was conducted to the Health and Disability Services Standards and the organisation's contract with the Bay of Plenty District Health Board. The audit process included, an interview with the prospective provider, review of policies and procedures, residents' records and staff files, observations, interviews with residents, family members, staff, the facility and quality and compliance manager, and a general practitioner.

Two areas requiring improvement were noted during this on site audit. They relate to ensuring there is always documented evidence for those residents who require only three monthly monitoring by their doctor and residents who require behaviour management plans have these details within their nursing care plan. One area of strength has been identified. The nursing team has healed a resident's wound which was considered intractable by hospital specialists. Areas requiring improvement had been

identified at the facility's certification audit in October 2015. These were reported on to the District Health Board and comments are included in this report.

Consumer rights

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

There are two residents who identify as Maori at the time of audit and appropriate policies, procedures and community connections ensure culturally appropriate support is provided.

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

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

The prospective owner has knowledge of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

A complaints register is maintained by the facility manager and includes all actions taken and the status of each complaint. The complaints process is easily accessed within the facility. Residents and family members receive information about this process on entry to the service.

Organisational management

The prospective owner has no immediate plans to change the management structure and a transition plan for the sale and ongoing management agreement includes the continuation of the present reporting functions. After the sale of the facility a management arrangement will remain in place which will involve the quality and compliance manager and an operations manager providing assistance and oversight of the facility on behalf of the prospective owner.

The facility manager has experience in management of aged care facilities as well as clinical nursing practice and as a quality practitioner in the aged care sector. There are operational management systems in place and the facility management reports against these to the current executive management team.

In a temporary absence of the facility manager there is an experienced registered nurse who can take over the manager's role, with support from the operations manager, the quality and compliance manager and the administrator.

A detailed quality and risk management plan documents the quality framework for the facility and provides clear directions for all staff to follow. The document management and control system is managed by the quality and compliance manager with new and updated documents sent to the facility with directions for electronic and hard copy versions to be updated. All documents reviewed were current.

Quality improvement data is collated, analysed and trends are identified, which are discussed and reported to all staff. These processes will continue following the change of ownership. A programme of internal audits is followed. When necessary, corrective action plans are developed, implemented and monitored until completion. Progress against the facility's quality and risk management plan is monitored through the monthly reporting process. Current risk and hazard registers were reviewed.

There are a range of human resources management policies and procedures which are followed by the facility manager. All recruitment and appointment of new staff follows accepted good practice in the sector. All staff have orientation training and ongoing training which they report is appropriate for them to maintain their skills and knowledge.

The facility manager develops a weekly roster following a documented process for staffing of the facility. This provides for the allocation of a range of nurses and caregivers and support staff in addition to the facility/nurse manager. Current rosters were

reviewed and meet the needs of residents in the facility at the time of the audit. The prospective owner will continue the present skill mix and rostering processes.

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

Continuum of service delivery

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

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

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

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

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

Safe and appropriate environment

Athenree Lifecare is a purpose built aged care facility with a current building warrant of fitness. The facility is all on one level with floor surfaces and handrails which promote safety and mobility for the residents living there. Regular environmental monitoring

occurs to ensure the safety of the facility. These checks link with the maintenance plan. Regular fire safety checks and evacuation practices occur and evidence of the approved evacuation scheme was sighted.

There are documented procedures for the management of waste and hazardous substances. All staff members have access to this information in training and through information on display in relevant utility rooms and the laundry. Cleaning and laundry processes are described and staff members responsible for these functions follow them.

Residents' rooms are personalised, have furnishings, windows, natural light and heating. There are communal spaces and external areas which are safe and accessible. The facility was well maintained, clean, tidy and odour free. Residents were observed to move around the facility independently or with assistance during the days of audit.

Appropriate security and emergency response arrangements are in place. This includes links with another aged care facility and with the Bay of Plenty District Health Board.

Restraint minimisation and safe practice

Policies and procedures provide a framework for the safe use of restraints and enablers within the facility. This includes the appointment of a restraint coordinator and an approval group. On the days of audit there were no enablers in use by residents. There are approved restraints in use. Families and those legally appointed to consent on behalf of a resident are involved in the decision making process.

There is an emphasis on the minimisation of restraint use and the restraint coordinator provides a monthly report to the quality group with collated data on restraint use. Restraints are monitored when they are in use and only restraints approved for use are implemented. There are regular evaluations of each resident's restraint use and this includes input from the staff who support the person, family members and their GP.

Quality monitoring and review of overall restraint use occurs through the quality group meetings with approval group members in attendance. There is evidence of reduction in restraint use where this can be safely managed for the individual.

Infection prevention and control

The service provides an environment which minimises the risk of infection to residents, service providers and visitors. Reporting lines are clearly defined and understood.

There is an infection prevention and control programme for which external advice and support is sought; this is reviewed annually. An infection control nurse is responsible for the programme, including education and surveillance.

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

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed.

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) |
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| Standards | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| Criteria | 1 | 98 | 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) |
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| 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Interviews with residents and family members of residents verified the services provided complied with consumer rights legislation.</p> <p>Policy documents, staff orientation programme, in-service training records, education programmes, interviews with staff, and satisfaction surveys verified staff knowledge of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Clinical staff were observed to incorporate their knowledge of the Code into their practice.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>The informed consent policy described procedures to ensure the residents were informed of all procedures undertaken.</p> <p>Documentation, observation and interviews evidenced information was provided to make informed choices. Informed consent was understood and was included in the admission process. The resident, and where desired family/whānau, were informed of changes in the resident's condition and care needs, including medication changes.</p> |

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| | | Residents' choices and decisions, including advance directives, were recorded and acted on where valid. Enduring power of attorneys were sighted for all residents in the secure dementia care unit. |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>Documentation, observation and interviews evidenced the service recognised and facilitated the rights of residents and their family/whanau to advocacy/support by persons of their choice. The facility has open visiting hours. Residents are free to access community services of their choice and the service utilises appropriate community resources, both internally and externally. Residents and their families were aware of their right to have a support person.</p> <p>At the time of admission residents are given information on the advocacy service including contact details. Residents, family members and staff confirmed on interview their awareness of the advocacy service and how to access this.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents were assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment at various locations, with the support of the service. The service acknowledged values and encouraged the involvement of families/whanau in the provision of care, and the activities programme actively supports community involvement.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaint process is easily accessed by residents and families. It is provided on entry to the facility and is available in a central location within the facility.</p> <p>The facility manager responds to, and manages, all complaints received at the facility. She maintains a register with all complaints, concerns and compliments. The complaints register was up to date on the days of audit. Complaints were responded to in a timely and respectful manner.</p> |

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| | | Staff members interviewed demonstrated an understanding of their responsibilities for supporting residents or family members to make complaints. They confirmed that they receive training and information about complaints which are received. |
| Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights. | FA | <p>The prospective owner at interview stated a knowledge of the Code, based on their family interactions with residential care and is aware of the need for services to uphold the Code.</p> <p>Interviews, observations and documentation confirmed residents were informed and understood their rights and were aware of the availability of the advocacy service. Information on the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) was displayed and accessible to residents.</p> <p>Discussion, clarification and explanation on the Code and the Advocacy Service occurred at admission and ongoing as required.</p> <p>Information was provided on the facility's range of costs and services.</p> |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | <p>Procedures were in place to ensure residents were kept free from discrimination, harassment, abuse and neglect, including the consequences of a staff member directing abuse at another person or being party to not reporting an act of abuse.</p> <p>Residents receive services which treat them with respect and have regard for their dignity, privacy, sexuality, spirituality and independence. All residents have their own room. Bathroom facilities have locks on doors to ensure resident's privacy is maintained when in use. Staff ensured that resident's privacy was maintained during personal cares. The privacy of resident information was maintained. All residents' clinical files were held in the nurses' station, or a secure cupboard; personal information in administration files was password protected; archived records were stored securely. The privacy of resident information was maintained during the verbal handover from one shift to the next.</p> <p>Staff demonstrated policy awareness and responsiveness to</p> |

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| | | <p>residents' needs. Staff were observed to respond promptly to calls for assistance, were noted to knock on residents' doors before entering and addressed residents by their preferred name.</p> <p>The service's policy related to abuse and neglect was well understood by those staff interviewed. Staff were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this.</p> <p>Residents and families interviewed confirmed that residents were treated respectfully at all times.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Documentation guides staff practices to ensure the two residents who identified as Maori have their needs met in a manner that respects and acknowledges the individuals cultural, values and beliefs. Interviews, documentation and observation verified these residents' cultural needs were identified upon entry as part of the care planning process and continued to be integrated into the residents' ongoing care. The organisation has a documented Maori Health Plan which identified the services priorities related to culturally safe services. The service recognises the relationship between iwi and the Crown and the principles of the Treaty of Waitangi (partnership, participation and protection). Whanau relationships and involvement in care are recognised.</p> <p>The local marae, and staff employed who identify as Maori, support the needs of Maori residents and assist if required.</p> <p>Staff received education in relation to cultural safety and the Treaty of Waitangi.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Evidence verified residents received and were consulted on culturally safe services which recognised and respected their ethnic, cultural and spiritual values and beliefs. Residents' personal preferences and special requirements were included in care plans reviewed, with appropriate interventions included to ensure these were met. There was also evidence in care plans of the resident and/or their family</p> |

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| | | being involved in the care plans development and ongoing evaluation. |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Systems are in place to ensure residents are free from discrimination, coercion, harassment and exploitations. Orientation/induction processes informed staff on the Code. The company's house rules, policies and procedures provided clear guidelines on professional boundaries and conduct, and inform staff about working within their professional boundaries.</p> <p>Interviews verified staffs understanding. Residents felt safe and receive a high standard of support and assistance and reported there was no sign of harassment or discrimination</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>The service encourages good practice, and consults with a range of specialist services from the District Health Board (DHB) when further guidance is required, as evidenced by the extensive input provided in the management of a wound, deemed chronic and unable to be healed. This management is identified as an area of continuous achievement based on the observed results. Policies sighted were current, relevant and referenced to related sources, legislation and the Health and Disability Services Standard requirements. Policies reflected current evidence based best practices, which were monitored and evaluated at organisational and facility level. Best practice information is also able to be sourced from the internet.</p> <p>Evidence verified a range of opportunities was provided to enable staff to provide services of a high standard. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and responded appropriately to medical requests.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Policy identifies that interpreter services are available and offered to residents with English as a second language. The service had an open disclosure policy which guided staff around the principles and practice of open disclosure. Education on open disclosure was</p> |

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| | | <p>provided. Communication with relatives was documented in the residents' communication records and incident forms. Evidence was signed of resident/family input into the care planning process. All family members interviewed stated they were informed in a timely manner about any changes to the resident's status and verified an environment conducive to effective communication.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The prospective owner interviewed stated that the prospective ownership is made up of two trusts of four members and this would make up the governance of the service. The prospective owner would take up the role of general manager, which will be an extra management role to that presently in place, and would report to the other trust members.</p> <p>Heritage Lifecare Limited (HLL) has a transition plan in place for the sale process. The prospective owner and HLL have agreed on the provision of management support for at least six months after the sale of the facility. This will be provided by the HLL operations manager and the quality and compliance manager, who are already familiar with the facility and visit regularly as part of HLL Group's operational management support. This was confirmed by the prospective owner.</p> <p>Athenree Lifecare provides rest home, dementia and hospital services, both medical and geriatric, for up to 43 residents. On the day of the audit there were 33 residents living at the facility: eight rest home residents, nine dementia – including one respite resident, and 17 hospital residents. Of the 10 vacant beds, four are the additional beds in the dementia unit which are still to be approved for use when the reconfiguration is completed.</p> <p>The facility manager is a registered nurse with experience in clinical nursing, quality and management in aged care facilities, including those with dementia units. She has a position description which describes the responsibilities and accountabilities of the role. Since the last on site audit the facility manager has taken on the clinical oversight responsibilities for the facility in addition to her management role. (See also standard 1.2.8)</p> |

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| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>In a temporary absence there is an experienced registered nurse working in the facility who is able to take on the facility manager's day to day responsibilities with support from the administrator and the operations and quality and compliance managers. The prospective owner stated that this will not change.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>HLL's quality and risk management plan is in place and will continue after the sale of the facility, this was confirmed by the prospective owner who stated that he was not conversant with all the legislative requirements for health service provisions. They have had experience in working in an industry that has legislative compliance requirements which included health and safety. The present quality and risk plan incorporates the requirement of this standard and all new staff receive information on it at orientation and at the regular monthly staff meetings. Meeting minutes are consistently recorded after the regular schedule of monthly meetings: the quality meeting in the first week of each month, the nurses meeting the second week and the whole staff meeting in the third week.</p> <p>Collated quality improvement data is discussed and shared with staff at each of these meetings. All relevant data is included in the meetings, including complaints, compliments, incidents, accidents, infections (in line with the facility's programme of surveillance), medication errors, use of restraints and enablers, hazards and risks. There is a programme of internal audits which has been implemented by the facility manager and other staff members. Results are also reported and discussed. Corrective action plans are developed when necessary in response to findings. Corrective action plans from external audits have been carefully implemented and documentation in relation to areas identified at the certification audit in October 2015 were sighted. Recent evidence provided to the Bay of Plenty DHB was confirmed through this audit.</p> <p>All policy and procedure documents are developed and reviewed by the quality and compliance manager. As noted this arrangement will continue for a period of time after the sale of the facility. All</p> |

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| | | <p>documents seen during the audit were current and have been reviewed appropriately.</p> <p>There is a current risk management plan which was reviewed in March 2016 through the quality committee. It includes relevant risks to the service with appropriate mitigation strategies.</p> <p>The manager's monthly reports contain data and narrative information which verifies whether the facility is meeting their quality plan goals. Review of the quality meeting minutes and a sampling of the monthly reports confirmed that progress is being made towards these goals.</p> <p>Staff members interviewed confirmed that regular meetings occur as scheduled and they receive information on collated quality data. They were able to discuss the data and their involvement in developing initiatives to address any trends.</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>Guidelines for essential notifications are described in policy. The facility manager is responsible for all notifications with assistance from the operations manager and quality and compliance manager.</p> <p>All adverse events are documented on an appropriate form, either the incident / accident form or the complaints form. Once an event is verbally reported to the registered nurse on duty and appropriate assistance is given, the staff member completes the written report.</p> <p>Sampling of hard copy forms and the electronic database used to record all events confirmed that there is understanding of the process by all staff members. A range of staff members were interviewed and all were able to describe their role in the adverse event process. Sampling of residents' files demonstrated that appropriate recordings are made on files to ensure that planning documents are updated as necessary and risks are managed.</p> <p>Family members commented that they are informed when events occur and provided with appropriate information.</p> |
| Standard 1.2.7: Human Resource Management | FA | The facility manager undertakes all recruitment of new staff using the |

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| <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>available policies and procedures to guide the selection and appointment process. Sampling of personnel files demonstrated that staff members she has appointed since taking up her position have been through the organisation's selection process which includes the requirements of these standards.</p> <p>An orientation is available for new staff members which provides them with the key information expected for anyone working in the aged care sector and specific information about their role. A checklist confirming that the orientation has been completed is included on each file. An annual training plan is developed and the 2016 plan is consistent with the guidelines in the organisation's policies.</p> <p>There is a mix of in-service training which runs throughout the year and external training to meet the needs of specific groups of staff (ie, nurses and caregivers, housekeeping, the kitchen team, and individual staff who have specific needs for their role). New caregivers are able to complete one of the qualifications relevant to their role and many already have these. The registered nurses maintain their syringe driver competency and some are completing Hospice palliative care modules. Staff who work in the dementia unit have completed the ACE (Aged Care Education) Dementia qualification and there is ongoing training on dementia in the annual plan.</p> <p>Staff members reported that the training has improved since HLL has taken over the ownership of Athenree. They enjoy the regular training they are receiving and access to external training.</p> <p>All health and allied health staff employed have their registration or practising certificates validated. A record is maintained of these to ensure that all are practising within their scope. All were reviewed and were current at the time of the audit.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>A documented tool for the allocation of staff to the needs of residents is used by the facility manager. With the current level of occupancy there are two caregiver roles within the roster which are not fully utilised but which are available to be used when the numbers and/or needs of residents require this. Some staff interviewed stated that there are times when these roles are needed. The facility manager</p> |

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| | | <p>and other staff report that the current roster is meeting requirements.</p> <p>The facility manager works Monday to Friday and is available on call at all other times. There is a registered nurse on duty at all times in the facility. There are two additional non-clinical days for a RN each week which are shared across the registered nurses. This is to enable them to undertake their other responsibilities across the month. Caregivers are assigned to work in the rest home and hospital area of the facility, or to the dementia unit if they have the appropriate training and experience.</p> <p>There is a cleaner and a laundry staff member. They both work five days a week and overlap on three days of the week. Similarly, there are two cooks and five kitchen staff who cover the needs of the kitchen across the week. With one cook and two kitchen staff working each day. In addition, there is a full time administrator, a maintenance person, two activities coordinators (one full time and one part time) who have oversight by a trained diversional therapist.</p> <p>The prospective owner stated that the present staffing arrangements will continue.</p> <p>Family members and residents interviewed state that they are satisfied with the care provided by staff.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>There was no personal or private resident information on public display during the audit. The resident's name and date of birth and national health index (NHI) were used as the unique identifier on all resident's information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were kept secure and only accessible to authorised people. On the day of admission all relevant information was entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI number, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all recorded in each resident's record reviewed.</p> <p>Archived records were held on site in a secure room. These are</p> |

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| | | catalogued for easy retrieval. |
| <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 process associated with entry to the service was explained by the facility manager (FM). Prospective residents are provided with detailed information about the service and included full details of the services provided, its location and hours, how the service was accessed and identifies the process if a resident requires a change in the care provided. Prospective residents are advised they can only be admitted when their level of required care had been assessed and confirmed by the Needs Assessment and Service Coordination (NASC) Service.</p> <p>Files reviewed contained completed assessments. Signed admission agreements met contractual requirements.</p> <p>Family members stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals were documented in the progress notes. This is verified by interviews with the RN and family members and sighted documentation</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>All aspects of medication management were consistent with legislative requirements and safe practice guidelines, as evidenced by documentation, observation and interview.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administered medicines</p> |

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| | | <p>were competent to perform the function they managed.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs were checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge had readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date were recorded electronically on the commencement and discontinuation of medicines. The three monthly GP review was recorded on the medicine chart. Resident allergy status was documented, and medication administration records were complete.</p> <p>The RN advised that medications were checked against the medication chart by an RN on arrival to the service. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication was returned to the pharmacy.</p> <p>There are no residents' who self-administer their medicines.</p> <p>Medication errors were reported to the FM and recorded on an incident form. The resident and/or the designated representative were advised. There was a process for comprehensive analysis and management of any medication errors, and compliance with this process is verified.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented May 2016 assessment of the planned menu.</p> <p>The cook manages food services for the facility. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional</p> |

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| | | <p>requirements were known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted. There was an effective and systematic approach to ensuring that residents' nutrition, fluid intake and weight was carefully monitored monthly and followed up when a concern arises.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted, together with records of fridge and freezer temperature monitoring.</p> <p>The effectiveness of chemical use in the kitchen was monitored by an external provider. The facility received monthly reports and recordings on the effectiveness of the programme.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes. The nutritional needs of residents in the secure unit are managed with food being available in the unit at all times, and the kitchenette in the unit being restocked daily. Staff interviewed verified food is always available should it be needed.</p> <p>There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>An interview with the FM verified a process existed for informing residents, their family/whanau and their referrers if entry was declined. The reason for declining entry is communicated to the referrer, resident and their family or advocate in a timely format that is understood. Assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p> |
| <p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>As confirmed by observation, interviews and documentation, RNs are responsible for all assessments, care plan development and care plan review. On admission, residents have their needs identified through a variety of information sources that included the NASC agency, other</p> |

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| | | <p>service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools.</p> <p>The information gathered informs the initial care planning process and takes place in the privacy of the resident's bedroom with the resident and/or family/whanau present if requested.</p> <p>Within three weeks of admission a lifestyle care plan is developed based on an interRAI assessment, and other assessments as clinically indicated. Assessments are reviewed six monthly or as needs, outcomes and goals of the resident change. All residents' records reviewed contained a current interRAI assessment in addition to other clinical assessments as indicated.</p> <p>A medical assessment is undertaken within 48 hours of admission and reviewed as the resident's condition changes (refer 1.3.3.3).</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Low</p> | <p>Files reviewed evidenced all residents have an individualised lifestyle care plan. The assessment findings in consultation with the resident and/or family/whanau, informs the care plan and assists in identifying the required support the resident requires from care staff, to meet their goals and desired outcomes. This is not always updated as residents' needs change.</p> <p>Progress notes, activities notes, updated assessments, evaluations and medical and allied health professional's notations are clearly written, informative and relevant, however care plans sighted do not include integration of all of this information.</p> <p>Care plans are evaluated three monthly or more frequently as the resident's condition dictated.</p> <p>Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p> | <p>FA</p> | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with ongoing assessment of</p> |

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| <p>meet their assessed needs and desired outcomes.</p> | | <p>residents' needs and desired outcomes, as outlined in the lifestyle care plan, with the exceptions identified above (refer 1.3.5.2).</p> <p>Short term care plans captured any change in resident status. Interventions were adequate and appropriate to meet the residents desired outcome. Well-established processes are in place to ensure continuity of care. An interview with the GP confirmed satisfaction with the standard of care provided to residents.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activity needs of residents are provided by an activity co-ordinator who is mentored by a qualified diversional therapist from another region. The mentoring process, via email, includes programme suggestions, review of the activities programme and guidance. The mentoring has been in place since the beginning of the year and a visit by the mentor is planned this month.</p> <p>Residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in assessment data.</p> <p>Residents from the secure unit attend activities outside the unit as the residents' conditions allow, in addition to activities being provided within the unit. A twenty-four hour approach to activities is provided within the unit, and the plan includes activities options that are in line with residents' previous lifestyle patterns and routines.</p> <p>The residents' individualised activity plan is reviewed as part of the lifestyle care plan with several exceptions, as identified in criterion 1.3.5.2.</p> <p>Documentation, observation and interviews confirmed activities reflected residents' goals, ordinary patterns of life and included normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the</p> |

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| | | <p>needs and preferences of the residents who choose to participate.</p> <p>A residents' and a family meeting is held each quarter. Meeting minutes and satisfaction surveys demonstrated the activities programme was discussed and that management were responsive to requests. Interviews verified feedback is sought on satisfaction with the activities offered.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>As verified by documentation, observation and interview, the RN is responsible for the evaluation of resident progress towards previously identified goals. Resident care was evaluated on each shift and reported in the progress notes. If any change is noted, it was reported to the RN. Lifestyle care plans are reviewed three monthly (refer 1.3.5.2).</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.</p> <p>Interviews, verified residents and family/whanau were included and informed of all changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Documentation and interviews verify residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist service provider assistance from the District Health Board (DHB). Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Support is available to transport and accompany residents to health-related visits outside of the facility, such as hospital appointments or visits to the dentist, if there was no family member available to accompany them.</p> <p>Acute/urgent referrals are attended to immediately, sending the</p> |

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| | | resident to accident and emergency in an ambulance if the circumstances dictated. |
| <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>Waste management guidelines are provided to staff members for the management, handling and disposal of infectious or hazardous substances. These were known and understood by staff members interviewed and summary information is on display in utility rooms.</p> <p>All hazardous substances and cleaning chemicals are stored safely and securely, both when in use and when stored. Material safety data sheets are available onsite for the cleaning and laundry products in use.</p> <p>Staff members interviewed have received training in the use of these products by the company representative. Adequate supplies of personal protective equipment (PPE) is available to staff in their work areas, with additional supplies available in storage. Specific supplies are available for outbreaks and spill kits are available throughout the facility.</p> <p>Additional procedures are in place to support one resident with Methicillin-resistant Staphylococcus aureus (MRSA) and a current wound. This includes procedures for the cleaning and management of their laundry. Staff members were interviewed and could describe the procedures required to appropriately support this person. Appropriate equipment was observed during the audit visit.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>Athenree Lifecare has a current building warrant of fitness which expires on 5 November 2016.</p> <p>The facility has been purpose built. It is on one level and has flooring which promotes independence for people who use mobility devices and hand rails throughout. Residents were observed to be moving about independently during the days of the audit.</p> <p>There are external areas which are accessible for residents both from the dementia unit and the main dining room and living room in the rest home and hospital area. There are fixtures for shade sails to be</p> |

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| | | <p>attached and outside seating is available.</p> <p>A maintenance schedule is in place which covers electrical testing and calibration of equipment. These are current and equipment is good working order.</p> <p>The prospective owner stated there are no plans to make changes to the facilities.</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>The showers and toilets are spread throughout the facility, seven of each. One bedroom has an ensuite bathroom and this is not included in these numbers as only the resident of this room uses this bathroom.</p> <p>There are three resident toilets in the dementia unit and five toilets designated for staff and visitors. The remaining five are all for resident use. Of the seven showers, two are in the dementia unit but only one of the two is used currently. Both are in working order and can be used if needed.</p> <p>Of the remaining five showers one is currently designated for the sole use of a resident with specific special requirements. The resident with special requirements also uses one of the toilets which is adjacent to the shower and their bedroom. This leaves four showers for the other residents.</p> <p>There are no reported issues of a lack of availability toileting or showering facilities for residents.</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 bedrooms are personalised and accommodate each resident's own belongings and any mobility equipment they use, as well as hoists if these are required. Residents were observed moving in their rooms safely using their equipment.</p> <p>All rooms for hospital level care residents meet their requirements and corridors are wide enough to accommodate the person being moved.</p> |

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| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>Both the dementia unit and the rest home and hospital area have a living/lounge room area and a dining room which can accommodate the residents. During the audit residents were observed during several meal times and during both days utilising these spaces.</p> <p>The areas have large windows with natural light, external views and decorations which are appropriate to the group. Residents and family members reported that they enjoy the environment at Athenree Lifecare and find it to be restful and relaxing. Those interviewed stated that they enjoy living at the facility.</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>The cleaning and laundry staff members confirmed the availability of documented procedures for their services. Guidelines for specific activities were seen in the laundry and the cleaner's storeroom. Both undertake routine monitoring of the effectiveness of the products they use and daily cleaning and laundry. Additional monitoring occurs through the internal audit system and this was sighted for the 2016 year.</p> <p>All cleaning and laundry products and chemicals are stored securely both when in use and for additional supplies. Secure storage was observed throughout the audit visit.</p> <p>Compliments from family members about laundry services were seen in the staff meeting minutes in 2016. The staff members interviewed demonstrated a focus on maintaining a high standard of cleanliness and efficiency in their work for residents. Residents clothing was observed to be clean and in good condition.</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>One of the RNs has overall responsibility for health and safety at the facility with two other staff members appointed. He was interviewed during the audit. This staff member has been involved in reviewing and updating the facility's emergency response plan which was done in consultation with the Bay of Plenty DHB. There is a formal arrangement with another aged care facility in Tauranga to provide support if needed in the event of a civil defence emergency.</p> |

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| | | <p>Fire evacuation training is included on the annual training plan for 2016. At interview with staff members they confirmed that trial evacuations also occur regularly through the year, and evidence of these was sighted.</p> <p>There is an approved evacuation scheme on record from September 2006. Although there has been physical reconfiguration of parts of the facility in preparation for an increase in the dementia unit, this has not made any change to the existing fire cells of the building.</p> <p>A range of alternative systems should main supplies fail are available. These include water storage, LPG gas with appropriate certificate of safety, additional food supplies, emergency response equipment and planning instructions for staff to follow. All emergency supplies have regular checks to ensure they are safe and functioning. Any supplies with expiry dates are cycled out of the emergency kits and replaced when appropriate.</p> <p>A call system operates in the facility which is responded to promptly. Main doors are locked at night and unlocked in the mornings with security checks by the overnight staff and a community patrol of the facility during the evening.</p> <p>The dementia unit has security doors at each entrance. There is a secure outside area which is accessible only from the dementia unit and provides a safe space for the residents to use. Staff were seen to ensure that the doors close behind them when they enter or leave the unit before they move away from the entrances. The entrance security is maintained.</p> <p>Interviews with a range of staff at different times confirmed their understanding of the emergency response and security procedures.</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> | <p>FA</p> | <p>The building has been constructed with all rooms having large windows to allow natural light and sun. There are eaves and shade sails to provide shade in summer. All windows have safety latches to allow fresh air to circulate without compromising safety. There are air conditioning units in main lounge rooms.</p> <p>Each resident's bedroom has a large window and some rooms have a</p> |

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| | | sliding door accessing an inner courtyard which has no external access. |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The executive management team from the organisation is responsible for ensuring there is a managed environment that minimises the risk of infection to residents, staff and visitors. The service had a documented infection prevention and control programme that is reviewed annually (November 2015) to maintain, monitor and establish new procedures covering infection control (IC) practices. The practices are guided by the IC manual, with assistance from an external IC advisor and the DHB IC nurse. It is the responsibility of all staff to adhere to the procedures and guidelines when carrying out all work practices.</p> <p>A RN is the designated infection control nurse (ICN). IC matters, including surveillance results, were reported monthly at the quality/staff meetings and to the facility manager (FM). Meeting minutes and monthly reports were sighted. There had been no outbreaks in the past year, and infection rates were low. The FM reports infection data to the organisation's quality and risk manager.</p> <p>At the main entrance to the facility there is a sign visible requesting anyone who was or has been unwell not to enter the facility, and reminding visitors about the need for hand washing. The IC manual provides information and guidance for staff on how long they must stay away from work if they have been unwell.</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 ICN was responsible for implementing the IC programme and reports directly to the FM. A position description is included in the IC programme.</p> <p>The ICN has attended IC management training courses, as confirmed in training records. If required, advice is able to be sought from a range of sources that included an IC manual produced by an external provider, the ICN at the District Health Board, the Public Health unit, online resources and articles.</p> |

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| | | The ICN confirmed adequate availability of resources and equipment for daily needs in addition to extra resources that may be required in the event of an outbreak. |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>An IC policy/procedure manual guides infection prevention and control practices. This complies with relevant legislation and current accepted good practices. The manual is reviewed every two years, with the last review being undertaken in November 2014.</p> <p>Housekeeping and kitchen staff were observed to be compliant with IC practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received annual education in IC and prevention at orientation and ongoing education sessions. The content of the training is documented and evaluated to ensure relevance and that the material has been understood. A record of attendance is maintained. Audits are undertaken to assess compliance with expectation. The ICN attended training at the DHB in March 2016 on outbreak management and further training is booked for later this year with an external IC provider.</p> <p>A programme to increase the uptake on influenza vaccinations this year has resulted in a marked increase in residents and staff being vaccinated.</p> <p>Resident education occurs in a manner that recognises and meets the residents' and the families' communication styles. Education with residents is generally on a one-to-one basis. This has included reminders about hand washing or the need for an increased fluid intake in warmer weather.</p> |
| Standard 3.5: Surveillance | FA | Surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) is the responsibility |

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| <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | | <p>of the ICN.</p> <p>Incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Monthly surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>Meeting minutes and interviews verified data was presented to the facility manager and quality/staff meetings and any ongoing corrective actions discussed and implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>A range of policies and procedures are available which meet the requirements of these standards and provide guidance on the use of restraints and enablers. A restraint coordinator is appointed and has a position description which outlines his role and responsibilities. An approval group is in place and meets monthly as part of the quality committee.</p> <p>Enablers are clearly defined. On the days of the audit no enablers were in use at the facility. However, there are appropriate systems in place to support their use should they be required for a resident.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | <p>FA</p> | <p>Approval of restraint use is described in the policies. The approval group is made of the restraint coordinator who is a senior RN and two other members of the nursing and care giving team. They meet, when needed, to approve the types of restraints to be used in the facility. Decisions on restraints for individual use are made when needed and confirmed at monthly quality committee meetings.</p> <p>At the time of the audit there were ten restraints in use and no enablers. Consistent monthly reporting of the number of restraints in use is made by the restraint coordinator to the quality committee. Of these files three residents files were reviewed with additional sampling of restraint documentation.</p> <p>All restraints in use are approved restraints as described in the</p> |

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| | | organisations documentation. |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>The assessment process includes all requirements of this standard. The restraint documentation ensures that all necessary information is recorded on each resident's file and is available at each stage in the process, particularly at assessment.</p> <p>The process incorporates assessment of the resident's needs, consideration of all possible alternatives to the use of restraints, discussion with the family representative and finally sign off by the resident's GP.</p> <p>The restraint coordinator was interviewed and described the process used. The approval group members are consulted and involved in exploring alternatives. Residents' files were sampled and the approval process is recorded as described in the policies with appropriate forms completed in a timely manner. Family members confirmed their involvement at interview.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | <p>The restraint coordinator maintains the restraint register and updates this each month. The register was reviewed with the coordinator during an interview and he described the purpose and status of each residents restraint. All changes in use are reflected on the register.</p> <p>The restraints approved for use by individual residents are monitored consistently when they are implemented. Each resident's restraint had a different frequency of monitoring based on the restraint type and the needs of the person.</p> <p>Recording sheets are maintained and were sampled for review on the day of the audit. For each person using restraints the monitoring completed was consistent with the pre-determined timeframes.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | FA | <p>Each resident's restraint is evaluated every three months. A sample of restraints in use were reviewed and their evaluations have been</p> |

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| | | <p>completed in a timely way since they have commenced.</p> <p>The evaluation process includes the requirements of this standard. Evidence was seen on two residents' files of their restraint being discontinued at the three monthly evaluation. All appropriate information was considered including a risk assessment and involvement of the family in the decision. Family members confirmed that they were included in this decision making and satisfied with the support their family was receiving.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>The quality committees monthly minutes include the restraint approval group discussion and analysis of restraint practice in the facility. Restraint and enabler use is discussed each month and overall trends.</p> <p>The restraint coordinator stated that having their meeting within the quality committee means that they are to evaluate the use of restraints and enablers in the context of all quality improvement data. Meeting minutes across the year demonstrate the requirements of this standard are met. An active process of minimising the use of restraint was observed, with two residents' restraints being removed.</p> <p>There is adequate training for staff members, which was confirmed through interviews. Review of the adverse events demonstrates that there are no events related to the restraint practice at the facility.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | PA Low | <p>Medical assessment by the GP occurs within 48hrs of admission, and residents are reviewed monthly by the GP, or three monthly if the GP has deemed the resident stable and able to be reviewed three monthly. Three of seven residents' files reviewed, are being reviewed by the GP three monthly, and there is no verification or documentation the GP had deemed the resident stable and not requiring monthly reviews. Evidence sighted supports the resident being stable at this time. Interviews and documentation verifies GP input is accessed when residents are unwell.</p> | <p>Residents are not always reviewed monthly by the GP. No evidence was sighted to verify the GP supports the resident does not require monthly reviews.</p> | <p>Evidence is provided to verify the GP supports any resident not requiring monthly visits.</p> <p>180 days</p> |
| <p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required</p> | PA Low | <p>Files reviewed evidenced all residents have an individualised lifestyle care plan. The assessment findings in consultation with the resident and/or</p> | <p>All residents have lifestyle care plans, however these are not always updated to describe the</p> | <p>Lifestyle care plans describe the support the resident</p> |

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| <p>support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | | <p>family/whanau, informs the care plan and assists in identifying the required support the resident requires from care staff, to meet their goals and desired outcomes. Progress notes, activities notes, updated assessments, evaluations and medical and allied health professional's notations are clearly written, informative and relevant.</p> <p>A resident in the secure unit, has numerous behaviour challenges. Whilst these are captured in behaviour monitoring charts, progress notes and medical reviews that prescribe changes in medications, there is no plan in place that captures an integrated approach to managing the resident's behaviour, including triggers or de-escalation strategies specific to this resident.</p> <p>A resident who has had a recent seizure, has a short term care plan in place to manage the initial event but this has not been integrated into the lifestyle care plan, when it has been identified as a long term condition, requiring ongoing management.</p> <p>A resident with an increased falls risk, has no update in the lifestyle care plan (refer standard 1.3.3).</p> <p>Activity plans of five of seven files reviewed are not updated to reflect changed in residents' needs.</p> <p>Interviews with staff verify familiarity with all aspects of the residents care of the residents, despite documentation not describing fully the support required.</p> | <p>required support needed, nor evidence service integration to enable a planned, integrated approach to providing resident focussed care.</p> | <p>requires to achieve the desired outcomes.</p> <p>180 days</p> |
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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 |
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| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI | Click here to enter text | <p>A resident with co-morbidities had a wound deemed by specialists as unable to be healed. Photographs evidence the wound prior to any intervention. Ongoing assessments, analysis and review are sighted. Management plans are sighted around all aspects of the resident’s care. Photographs are used to evaluate and verify the effectiveness of the wound management strategies. The infection was resolved, nutritional status improved and diabetic status monitored to ensure good control. Expert guidance was sought as needed and the wound has nearly healed. Interviews verify staffs’ knowledge of wound care management, analysis and review. An interview with the resident verified comfort and satisfaction with the care provided</p> |

End of the report.