

# Waihi Senior Citizens Home Incorporated - Hetherington House

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Waihi Senior Citizens Home Incorporated	
<b>Premises audited:</b>	Hetherington House	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 4 July 2016	End date: 5 July 2016
<b>Proposed changes to current services (if any):</b> None		
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> 44		

# 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Hetherington House (Waihi Senior Citizens Home) is owned and run by a community charitable trust overseen by a board of trustees consisting of 12 members. It provides care for up to 50 residents. Three levels of care are offered being rest home, hospital and secure dementia care.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

There are two areas identified for improvement related to activity planning for dementia care residents and the need to obtain an updated evacuation plan approval.

## 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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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There were no residents who identify as Maori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the residents as individuals and as a collective.

Written consents are obtained from the residents' families/whanau, enduring power of attorney (EPOA) or appointed guardians, when necessary.

Residents are encouraged and supported to maintain strong community and family links.

The organisation respects and supports the right of the resident to make a complaint. All documented complaints sighted have been fully investigated, and closed. At the time of audit there are no open complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The service undertakes business planning and quality and risk processes to ensure all aspects of service delivery are provided to meet residents' needs.

The facility manager (registered nurse) is responsible for the overall management of the facility and is accountable to the board. They are supported by a senior registered nurse who is the second in charge and responsible for all clinical oversight.

The documented quality and risk processes are implemented by the service to support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among staff, residents and family/whānau, as appropriate. Corrective action planning is implemented to manage any areas of concern or deficits.

The service implements staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes identify good practice and meet legislative requirements.

Resident information is accurately recorded, securely stored and unable to be accessed by the public. Staff have easy access to all resident files.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the resident. This is developed with the resident, family and existing community supports and health care professionals. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan,

as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have 'interRAI' assessments completed and individualised care plans related to this programme.

Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a three week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## 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.

Waste is managed to protect residents, visitors and staff from harm.

There are documented emergency management response processes which are understood and implemented by the service providers. The building has a current building warrant of fitness. The fire extinguishers are checked annually by an approved provider. Medical and electrical equipment is checked to meet legislative requirements.

Documentation sighted and interviews with residents and family/whānau identify that the facilities meet residents' needs. Regular maintenance occurs in a timely manner. Currently all bedrooms are single occupancy, there are adequate toilet, bathing, hand-washing, dining and relaxation areas.

The facility is appropriately heated and ventilated. The outdoor areas provide suitable furnishings and shade for residents' use.

The secure dementia care unit has a secure outdoor area for residents' use.

## 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.

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.

At the time of audit there are six bedside rail restraints and three enablers in use. Restraint approval and assessment processes have been undertaken to meet the requirements of this standard. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints. Restraint is used for safety reasons only. Monitoring and evaluation processes are conducted according to identified risk. All restraint requirements are clearly identified in residents' care plans.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported to staff and residents where appropriate

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	2	0	0	0
Criteria	0	99	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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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	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents and a copy of this information is in the client's room.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents' rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights in a manner that was individual to the resident's needs.</p>
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents' files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative's care and decision making.</p>

make informed choices and give informed consent.		
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.  Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the local shopping centre or community and school groups regularly visiting the facility.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service implements a documented complaints management policy and procedures as confirmed by the facility manager and in documentation sighted. Complaints are recorded in a register which identifies the nature of the complaint and all follow up actions undertaken. Complaints processes which reflect a fair complaints system are discussed with residents and family/whanau as part of the admission process. Complaints forms are available at the main entrance. Residents, family/whānau and staff reported during interview that they understand the complaints processes in place and are aware of where to find written complaints forms.  Complaints are a standing agenda item for quality and risk meetings as confirmed in meeting minutes sighted.  There were no outstanding complaints at the time of audit and all complaints made have been resolved in-house.
Standard 1.1.2: Consumer Rights During Service	FA	The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is evidenced in the admissions

<p><b>Delivery</b></p> <p>Consumers are informed of their rights.</p>		<p>agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff.</p>
<p><b>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</b></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 residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The families/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</p>
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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>The senior registered nurse reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaises with family/whanau at time of admission and regular intervals to ensure cultural or religious visits continue as appropriate. Residents have access and are supported to attend services within the facility and in the community.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were</p>

respect their ethnic, cultural, spiritual values, and beliefs.		happy with the care provided by those staff who also identify with a different culture.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	Evidence-based practice was observed and evidenced in interviews with the registered nurses, caregivers and care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The families/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.  All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The trust philosophy, mission statement and values are clearly documented. The business plan in place is dated 2014 with a full review being undertaken in January 2015. Progress against set goals is monitored by a sub-committee of the board of trustees. The quality plan sighted describes how the trust's goals are monitored and evaluated against monthly facility reports showing how resident needs are being met. Monthly reporting of quality data is reviewed at health and safety and quality meetings and this information is shared across the service.  On the days of audit there were 44 beds occupied consisting of 13 hospital, 31 rest home which include six secure dementia care residents.  The facility manager who has oversight for all service delivery is a registered nurse with a current practising

		<p>certificate and has been in the role for five years. They are supported by a senior registered nurse who is second in charge. Both managers maintain ongoing education related to the roles they undertake both clinically and managerial. They oversee all aspects of service delivery and they are supported by a team of registered and enrolled nurses.</p> <p>Interviews with residents and family/whānau confirmed that they are very happy with the services provided and that they can contact the manager at any time. Management interaction with residents, family/whanau and staff was observed on the days of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The service ensures the day to day operation of the service is managed effectively during sick leave or holidays. The senior RN is the second in charge. They have worked at the facility for over 20 years and they cover the facility manager role as required. When the senior RN is away one of the other six RNs from the floor steps up to perform the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. For example, the corrective actions taken related to incorrect counts of controlled medication resulted in having the controlled medications counted monthly by the pharmacist. Information is shared at staff and management meetings as confirmed in meeting minutes sighted.</p> <p>Quality data collected is analysed, evaluated and trended against previously collected data. Information is used to inform annual objectives to ensure services meet resident needs. The annual review of all 2015 quality statistical data reported to the board was sighted.</p> <p>Continuous quality projects are documented, such as the update of laundry equipment to reduce staff handling of soiled linen.</p> <p>Actual and potential risks are identified and documented in the hazard register showing how the risks are managed. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. Actions taken are identified</p>

		<p>in the health and safety meeting minutes. (The health and safety meetings also covers quality data reviews). Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. This is confirmed in documentation sighted.</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>Adverse event reporting, as identified in policy, is implemented by the service. The management team confirmed their awareness of the requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Incident and accident forms were reviewed for 2016.</p> <p>Interviews and documentation sighted confirmed family/whānau are notified of any adverse events or concerns staff have about residents.</p> <p>The facility manager and the senior RN confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. One example relates to the purchase and use of an extra low bed for a resident who was at high risk of falling out of bed. This has resulted in a decrease in the number of falls.</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>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. The staff files reviewed contained job descriptions, completed orientation records, competencies related to the roles performed, staff education, reference checks and police checks for more recently employed staff. When staff complete the orientation programme a letter is then placed in their file stating all aspects of orientation have been completed. It was suggested that the booklet staff complete for orientation is kept at the facility to give a more robust auditable record of orientation completion.</p> <p>The facility had a documented process in place to show that staff who require annual practising certificates have them validated upon commencement of employment and yearly thereafter. The senior registered nurse ensures annual competencies such as medication management are up to date and documented.</p> <p>There were electronic individual staff education attendance records covering both on-site and off-site training and education attended. Staff are encouraged to maintain a portfolio of education and four RNs maintain their professional development portfolio via the Waikato District Health Board professional development programme. Staff who work in the secure dementia unit have either completed or are in the process of completing a recognised age care dementia qualification.</p>

		<p>The education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relates to age care and health care services. Three RNs and the facility manager are interRAI trained and all RNs hold a current first aid certificate.</p> <p>Resident and family/whānau members interviewed confirmed that services are delivered in a professional manner and that their needs are met by the service.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>Policy states that Hetherington House employ sufficient suitably qualified staff to meet or exceed requirements. Rostering of staff reflects each shift has staff with skills and knowledge to ensure all residents' needs are met. A review of three weeks rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs.</p> <p>Residents interviewed stated all their needs have been met in a timely manner.</p> <p>The diversional therapist works eight hours per day, Monday to Friday. The activities assistant works 4.5 hours on a Monday. A physiotherapy assistant works six hours, three days a week. There are dedicated kitchen, cleaning and laundry staff seven days a week. All shifts are covered by a registered nurse. The senior nurse manager has four days a week as dedicated 'paper days' and works on the floor one day per week. The facility manager works Monday to Friday and is on call.</p> <p>The secure dementia unit has a dedicated staff member allocated for all shifts. They are relieved for breaks by a floor staff member as required.</p>
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is 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, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for seven years.</p>
Standard 1.3.1: Entry To	FA	<p>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or an enduring power of attorney</p>

Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		(EPOA).  Vacancies are updated daily through Eldernet. Staff contact the chief executive officer and/or senior registered nurse if enquiries are made by potential perspective residents and/or their family members, and if outside working hours, an appointment is made.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit one resident was self-administering medications.  Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment rooms which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented.  The 14 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.  There are documented competencies sighted for designated care staff responsible for medicine management. The senior care giver administering medicines at the time of audit demonstrated competency related to medicine management.

<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>	FA	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safety requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a three week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner. All main meals are supported by morning and afternoon tea which includes home baking. There is a confectionery and hot beverage vendor machines and water cooler available to residents and family.</p> <p>All meals are cooked and served directly from the kitchen and served in the adjacent dining room. A baine marie takes food from the kitchen to the dementia unit. Residents have the option of trays in their rooms, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The chief executive officer and senior registered nurse interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	FA	<p>The service has implemented the electronic interRAI assessment and specific assessment tools for all residents remain paper based. Assessments are carried out by a registered nurse appropriate to the level of</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure ulcer risk assessments.</p> <p>The family/whanau interviewed reported their relative receives 'above and beyond the care required' to meet their relative's needs.</p>
<p><b>Standard 1.3.5: Planning</b> Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The nine residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the senior registered nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b> Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurses and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired</p>

		<p>goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities  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>PA Low</p>	<p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices of the aged care residents.</p> <p>The facility has one diversional co-ordinators, one who works four days a week, a total of 32 hours per week and is supported by a assistant therapist whom works two days a week, a total of twelve hours. The weekly activities plan/calendar sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertise the upcoming activities on the calendar by providing this to residents on the notice boards through the facility and individually in the bedrooms. Regular activities include daily newspaper reading and exercises, church services, happy hour, regular visiting entertainment, visiting individuals and groups from the community and includes weekly bus trips. All residents are encouraged and supported to partake and belong to groups in the community. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>A challenging behaviour and assessment tool and monitoring form is developed for residents in the dementia unit however care plans are not evidenced to support residents whom are presenting with challenging behaviours over a 24 hour period.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p>

<p><b>Standard 1.3.8: Evaluation</b> Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></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>There are four GP's who visits the residents at the facility which also includes an on call component. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</p>
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated</p>	FA	<p>The service has policy and procedures which are implemented related to all waste management. It identifies how waste products are disposed of to ensure residents, visitor and staff are protected from harm. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes. Chemicals sighted are stored securely. Safety data sheets were sighted for the chemicals in use.</p> <p>Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons, masks and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.</p>

during service delivery.		
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 2 August 2016.</p> <p>There is a process in place to identify and manage maintenance both long term and reactive. The maintenance person undertakes regular maintenance and organises outside contractors as required. Electrical safety testing and clinical equipment calibrations occurs at least annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. The facility has ample storage space for all equipment. Oxygen cylinders are correctly secured. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents. This was last conducted in January 2016 and gained a 100% compliance.</p> <p>Hazards are documented and overseen by the health and safety committee.</p> <p>There is a secure outdoor area attached to the dementia care unit. All outdoor areas have appropriate seating and shaded areas which are easily accessible for all residents including wheelchair access.</p> <p>Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Residents are provided with adequate toilet/shower/bathing facilities which are centrally located in each wing. Eight bedrooms have a full ensuite bathroom shared between two bedrooms. All bedrooms have handwashing facilities. There is one spa pool which has a ceiling hoist if required. Monthly water clarity testing and pool dosing is clearly documented.
Standard 1.4.4: Personal	FA	All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>residents to place personal belongings. At the time of audit all bedrooms are single occupancy. One bedroom in the care facility has two beds but is usually used by couples if required. Only one resident is in the bedroom on the day of audit.</p> <p>Since the previous audit, a community project was undertaken where local businesses sponsored a bedroom for an upgrade. This has resulted in the upgrading of resident bedrooms to include carpet, painting and curtains as appropriate.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. In the care facility there are three lounge areas, two are small quiet lounge areas that can be used by resident or for family/whanau meetings as required. The large hospital lounge is used to undertake physiotherapy as required and the equipment is set up in one clearly divided area. The dining area is separate.</p> <p>In the secure dementia unit, the lounge and dining area is open plan and divided by furniture placement. Activities are undertaken in this open plan area.</p> <p>Residents in the secure dementia unit have activities in the unit and also attend activities in the care facility such as singing and attending outside entertainers' presentations.</p> <p>Residents and family/whānau voiced their satisfaction with the environment.</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>	FA	<p>The service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and material data sheets are readily available. The laundry is appropriately equipped with clearly defined clean and dirty areas. The equipment in the laundry is checked regularly. The effectiveness of the chemicals used is monitored monthly by the provider. The housekeeping supervisor who works in the laundry stated all laundry is visually inspected post wash when being folded and ironed to ensure it is clean. Correct chemical usage is overseen by the approved provider who also presents regular education to staff.</p> <p>During interview, residents and family/whānau confirmed they are very happy with the laundry services provided. Interviews with cleaning and laundry staff confirmed they comply with policies and procedures and they are happy with the products used.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	PA Low	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment,</p>

<p><b>Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>emergency lighting, and communication. Fire extinguishers are checked annually by an approved provider. (Last undertaken in August 2015). The fire hose reels were last checked in May 2015 as the facility manager was told they no longer need to be checked. Once this was discussed at audit it was organised for the hose reels to be checked. This was to occur on the second day of audit but the facility was still waiting for this to occur when the auditors left the facility.</p> <p>Staff education occurs during orientation and at least annually related to management of emergency procedures which last occurred in January 2016.</p> <p>Emergency supplies and equipment include food, water and an emergency generator being available with a nearby hire facility as agreed in a memorandum of understanding giving Hetherington House priority use. The service has a fire service approved fire evacuation plan dated 1 December 1993. On the day of audit, the fire service informed the provider that this evacuation plan needs to be updated owing to the addition of a lounge area in the secure dementia care unit. Six monthly trial evacuation drills occur and are well documented. (Last undertaken in January 2016 with no follow up required).</p> <p>Staff are required to check the doors and windows are locked at dusk. Visitors to the facility after this time need to ring the front door bell for entry. There is a contracted security firm who undertake twice nightly random checks of the grounds. Additional external outdoor lighting of the grounds and car parking areas have been installed following an incident with an intruder in the grounds. (Police report sighted). Staff and residents stated they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe.</p>
<p><b>Standard 1.4.8: Natural Light, Ventilation, And Heating</b></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 resident areas have natural light and ventilation via opening doors and windows. Appropriate heating ensures the facility is kept at a comfortable temperature throughout the year. This is confirmed during resident and family/whanau interviews.</p>
<p><b>Standard 3.1: Infection control management</b></p> <p>There is a managed</p>	FA	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>A RN is the infection control coordinator and is responsible for following the programme as defined in the</p>

<p>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>		<p>infection control manual. Infections are monitored by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meeting. If there is an infectious outbreak this is reported to staff, management and where required, to the DHB and public health departments.</p> <p>The chief executive officer interviewed (as the infection control officer was away at the time of the audit), reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</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 registered nurse has the role of infection prevention and control coordinator. Infection control issues are identified to staff. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources, including the laboratory diagnostic services and the GP. The infection control coordinator regularly attends infection control education. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management, cleaning disinfecting and sterilisation, waste management, construction and renovations. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The registered nurses and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the quality assurance manager. Infection control in-service education sessions are held and resident education is provided, as and when 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	All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors wounds, urinary tract infections, upper and lower respiratory tract infections, skin and soft tissue, oral, eye and gastroenteritis infections. Antibiotic use is also monitored and evidenced as discussed with the GP. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff, and where appropriate, resident meetings.  Infection rates for urinary and respiratory tract infections fluctuate. This is mainly due to six residents with chronic medical issues. Care planning and intervention/evaluation showed how staff were reducing and minimising risk and trends and actions to take to reduce the spread of infections for individual residents and as a facility. All six residents were assessed as being at the appropriate level of care.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. Policy states that the service aims to minimise the use of restraint. The use of enablers is voluntarily and used to assist residents to maintain independence.  The service had one bedside rail enabler and five bedside rails as restraint at the time of audit. Staff

actively minimised.		verbalised their understanding and knowledge related to safe restraint and enabler use during interview.
Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The senior RN is the restraint coordinator and their job description identifies their lines of accountability for restraint. They have held this position for many years and can verbalise all actions to be taken prior to and during restraint use. All staff interviewed are aware of the processes to be undertaken prior to restraint use. Education is offered annually and was last presented in June 2016. This included behaviour management.  Policy identifies the approval processes which is implemented by the service. Two file reviews conducted for restraint use identify that a review of the use of restraint was conducted one month following the first applied restraint and then again at three months building up to a six month review as there were no identified risks to the residents. The restraint coordinator stated this is done sooner if any issues arise. The only current approved restraints in use are bedside rails.  There is no restraint used in the secure dementia unit.
Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments are undertaken by a RN prior to restraint being approved. The assessment meets the intent of this criteria. This is confirmed in two resident file reviews undertaken for restraint use only. Assessments are well documented and the information is congruent with what is shown on the resident's care plan.
Standard 2.2.3: Safe Restraint Use  Services use restraint safely	FA	Approved restraint is only applied as a last resort. The assessments sighted identify other techniques were trialled prior to restraint approval.  Each episode of restraint is documented to provide an accurate account of the indication of use, the duration and its outcome. Each person's restraint is individualised and there is a documented rationale and risk rating which then shows a graduated documented monitoring requirement of up to two hours. (All restraints have a requirement of at least one hourly visual checks). Restraint is used for safety reasons only to prevent falls.  The restraint register is kept up to date and all information sighted in the register allows an auditable account of all restraint use.
Standard 2.2.4: Evaluation	FA	Documentation sighted shows that each episode of restraint is reviewed according to risk. Newly commenced

Services evaluate all episodes of restraint.		<p>restraint is evaluated visually on a daily basis by staff who report this in the resident progress notes and then a review is undertaken by the restraint coordinator at one month if there have been no incidents. This is done sooner if any concerns are raised.</p> <p>Three monthly reviews involving the multidisciplinary team and the family/whanau are conducted for the first 12 months and then this is extended to six monthly if there are still no issues or concerns raised. The staff monitor each episode of restraint use and document at least two hourly stating changes of position and other nursing actions taken. All bedside rails have protective covers to help prevent injury.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator writes a comprehensive report six monthly of all restraint use and presents this to the quality and risk committee. The report identifies the numbers of and types of restraint in use, any issues that have arisen and trends with other months of restraint use. The report sighted for April 2016 identified that the use of bedside rails varies between five and seven at any given time and that there had been no incidents related to the previous six months restraint use. A member of the board attends the quality and risk meetings so they are aware of what is occurring at the facility.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	All residents in the dementia unit have a profile and care plan developed on admission which includes social activities (past and present). A challenging behaviour assessment tool and monitoring form is completed when residents present with challenging behaviours. The Diversional Therapist documents and evaluates three monthly in the progress notes, however what is not evident is a description of how best to support a resident with challenging behaviours over a 24 hour period. Family interviewed stated that they were happy with the activities and interventions on offer. The review of files was extended in the dementia unit from three to six to further review this specific information.	A care plan of the activities that meet the residents needs in relation to individual diversional, motivation, and recreational therapy during the 24 hour period is not evidenced.	To provide a care plan of how the behaviour of each resident in the dementia unit is best managed over a 24 hour period.  180 days

<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA Low</p>	<p>The service has a current fire evacuation dated 1 December 1993. However, the fire service has requested that the facility applies for an updated evacuation scheme. A letter held by the facility from the Ministry of Business, Innovation and Employment states that the fire hoses no longer need to be checked as part of the compliance for building warrant of fitness. Therefore, the last check of the hose reels was undertaken in May 2015.</p>	<p>An email which arrived at the facility on the day of audit from the fire service requesting that the facility applies for a new fire evacuation plan owing to an extension made to the secure dementia unit lounge area. The hose reels have not been checked in the last 12 months as is required to meet good practice requirements.</p>	<p>Ensure all legislative requirements are met to reflect best practice.</p> <p>180 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

End of the report.