

Heritage Lifecare Limited - Colwyn House

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:

Legal entity: Heritage Lifecare Limited

Premises audited: Colwyn House

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 31 August 2016 End date: 1 September 2016

Proposed changes to current services (if any): Heritage Lifecare Limited (HLL) are in negotiations on the purchase of this facility and hope to take over the facility at the end of 2016.

Total beds occupied across all premises included in the audit on the first day of the audit: 69



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

Colwyn House provides psychogeriatric and dementia/medical level care for up to 69 residents. The service is operated by Anglican Care Waiapu Limited and managed by a facility manager and a clinical manager. Families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the Hawke's Bay district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with family, management, staff, a general practitioner and the quality and compliance manager for the prospective owner. Residents spoken with by the auditors provided limited information, given their cognitive abilities.

Two areas requiring improvements are identified at this audit relating to residents' privacy and complaints management.

A strength of this organisation is their focus on education and management of challenging behaviour and restraint minimisation.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

The prospective provider representative has aged care management experience and is fully informed of the obligations of the Code.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health providers, which contributes to ensuring services to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Anglican Care Waiapu is the governing body and is responsible for the service provided at Colwyn House. Anglican Care Waiapu have a strategic plan which includes the vision, purpose, mission statement, core values and passion of the organisation; this is used to develop a facility specific business plan.

The suitably qualified facility manager is supported by a clinical manager who is a registered nurse.

There is an organisation wide quality and risk management plan and systems are in place for monitoring the services provided, including regular weekly meetings and monthly reporting by the facility manager through to the governing body. This includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed.

Adverse events are documented on incident forms. Corrective action plans are being developed and implemented where required. Formal and informal feedback from families is used to improve services. Actual and potential risks and hazards are identified, mitigated and are up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. An annual training plan and a record of ongoing training is in place.

Staffing levels and skill mix meet contractual requirements and the needs of residents. Senior staff are on call after hours and at weekends.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained.

The quality and compliance manager for Heritage Lifecare Limited (HLL) provided evidence of a transitional plans which does not include change to the present management structure. HLL will review the present quality and risk process, policies and procedures and may merge some these in the future.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day and are supported by care and allied health staff and a designated general practitioner. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any problems that might arise. All residents` files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Family members interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health and disability services as required, with appropriate verbal and written handovers.

The planned activity programme is supported by an occupational therapist provides residents with a variety of individual and group activities and maintains their link with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety training provided every two years. The kitchen is well organised, clean and meets food safety standards.

Safe and appropriate environment

The facility has been purpose built with additions over time. Rooms are all single, some are, ensuite, and the remainder share communal toilets and showers. All rooms are of an adequate size to provide personal care related to the services being provided in that area.

Building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative maintenance plan is in place and reactive maintenance occurs.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Laundry services are available on site and cleaning and laundry staff are employed, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. This is a secure facility with systems in place to ensure safety and security of staff and residents.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Twenty restraints are in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enablers are generally not used due to the cognitive ability of the residents. However, staff are aware of the difference between restraint and enabler use. Staff receive training at

orientation and on an ongoing basis, including all required aspects of restraint use, alternatives to restraint and dealing with challenging behaviours. Staff demonstrated a sound knowledge and understanding of the restraint processes.

Infection prevention and control

The infection prevention and control programme is led by a registered nurse who has completed training and aims to prevent and manage infections. There are terms of reference for the infection control committee which meets quarterly. Specialist infection prevention and control advice is able to be accessed from the District Health Board and a microbiologist from the laboratory service, as required. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	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)
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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Colwyn House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent polices provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation`s standard multipurpose consent form including for (eg, outings, transportation, photographs for clinical purpose, and photographs for the medication and personal record folders and for sharing information).</p> <p>Advance care planning, establishing and documenting enduring power of</p>

		<p>attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the residents' records. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed with the clinical nurse manager.</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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>	PA Low	<p>The Anglican Care Waiapu has an organisation wide complaints policy with associated forms that meet the requirements of Right 10 of the Code. The facility manager and clinical manager stated information is provided to family members on admission and there is complaints information available at reception and the nurses' station. This was confirmed by staff during interview. Family members spoken with know of the complaints process and who they would approach if they had a problem, this included the facility manager and the registered nurse on</p>

		<p>duty.</p> <p>The complaints register reviewed showed that nineteen complaints have been received over the past year, with eight so far this year. It includes documentation of actions taken, through to an agreed resolution. The register does not give the dates when complaints have been acknowledged and review of four out of eight complaints this year did not have documentation of this occurring. The register showed the required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed they have received related training and demonstrated a sound understanding of the complaint process and what actions are required. Training was confirmed on review of staff training records.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Family members interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service on admission to the service. The information is accessible in the information pack provided and on the reverse of the Code pamphlet. The Code is displayed throughout the facility in poster form and pamphlets together with information on advocacy and how to make a complaint are located at reception. Feedback forms are also available.</p> <p>The prospective provider currently provide residential services and management advisory services for other residential support services and are aware of the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	PA Low	<p>Families confirmed, and it was observed, that residents receive services in a manner that has regard for their dignity, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information that is not able to be overheard). All residents have their own room. An ablution block in one wing has two toilets and two showers</p>

		<p>cubicles and the lay out does not allow for privacy to be maintained.</p> <p>Residents are encouraged to maintain their independence and to be able to move freely within their respective areas in the home. Outings with family are encouraged for residents that are able. Each care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviewed understood the service's policy on abuse and neglect, including what to do should signs of abuse and neglect be identified. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in the staff and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support the eight residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whānau to Māori residents. There is a current Māori Health Plan developed with the input from cultural advisers. Current access to resources includes the contact details of an Anglican Priest who is the cultural adviser for this service. Guidance on tikanga best practice is readily available and is supported by staff who identify as Māori in the facility. There are twenty-five staff who identify as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, which required interventions and special needs were included in all care plans reviewed (eg, tikanga partnership of the Anglican Church and initial care planning evidences cultural needs information is sought). A family satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect that this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through (eg. clinical guidelines, transitional care package being implemented, the allocation of staff within this specialised service, staffing levels and managing challenging behaviour). The GP has a special interest in dementia and psycho-geriatric care and management. The general practitioner (GP) locum confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education opportunities and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice noted are the development and implementation of the activity programme for the twenty four hour period and the strength of the palliative care/family/whānau support available. Family members interviewed were very complimentary about the nursing and care staff.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family members stated they were kept well informed about any changes to their relative`s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in resident`s records reviewed. There was also evidence of family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the HBDHB and the Māori Health Advisor for the service when required. Staff knew how to do so, but due to the nature of this aged care related service, mostly the staff are dealing with the families. Most residents speak English and use of family/whānau members is encouraged.</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>Anglican Care Waiapu, Board of Directors have developed a strategic plan that outline the purpose, values, scope, direction and goals of the organisation. This is used by each facility manager, with input from the regional operations manager and the clinical quality and compliance manager, to develop a business plan, which is signed off by the regional operational manager. These are reviewed annually. These documents describe annual and longer term objectives and the associated operational plans. The facility manager receives reports from senior staff which informs their monthly report to the regional operations manager. The reports are templated and provide evidence against the objectives and key performance indicators. The information provided then goes to the Board. A sample of reports reviewed shows adequate information to monitor performance is reported including, quality and risk, financial information, complaints, and health and safety. Benchmarking of data with other facilities is occurring.</p> <p>The service is managed by a facility manager who has a background in commerce and banking and has been in this role for two and a half years. They have decided to leave this role and employment will terminate mid-September. The general operations manager will step into the role until a suitable person is employed. Responsibilities and accountabilities are defined in a job description, individual employment agreement and delegated authorities` policy. The facility manger and</p>

		<p>clinical quality compliance manager confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through attending conferences and updates from the Ministry and New Zealand Aged Care Association. The facility manager is supported by the clinical manager who is a registered nurse.</p> <p>The service holds contracts with Hawke's Bay DHB for psychogeriatric services, dementia/medical services, respite and transitional services. Sixty nine residents receive services under these contracts. On the day of audit there were twenty dementia residents and forty nine psychogeriatric residents, four of whom were under 65 years of age.</p> <p>The prospective owners (HLL) provide aged related services and management services to other service providers presently and have a working knowledge of the contracts the present owner has with the district health board. The quality and compliance manager provided evidence of planning for the transition and stated that the structure within the facility would remain unchanged, including registered nurse full time equivalents. The Hawke's Bay DHB and the Ministry are aware of the plan to purchase this service.</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>When the facility manager is absent, the clinical manager carries out all the required duties under delegated authority. During the absences of the clinical nurse manager the clinical coordinator, who is a registered nurse would oversee the clinical aspects of the facility. They are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The HLL quality and compliance manager stated that they will continue with the present management structure and arrangements including contingencies when senior staff are not available.</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 organisation has a quality and risk system that is overseen by the Anglican Care Waiapu clinical quality and compliance manager and delegated to a facility quality coordinator who is a registered nurse and has a job description that outlines their responsibilities. The quality and risk plan reflects the principles of continuous improvement and was</p>

	<p>understood by the staff spoken with. This includes the management of incidents and complaints, annual audit activities, a regular family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and skin tears.</p> <p>There is a weekly clinical team meeting which includes some element of the quality plan and a monthly health and safety, quality and risk meeting. The attendees include staff from most areas of the facility. The minutes of these meetings confirmed adequate reporting systems and discussion occurs on quality matters including pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Anglican Care Waiapu have quarterly quality coordinator meetings to allow for education and discussion on quality issues. Monthly reports go to the clinical quality and compliance manager and the facility manager, this allows for regular review, analysis and trending of quality indicators to occur. There was evidence of corrective actions being undertaken and carried forward to the next meeting for follow through. Minutes of staff meetings showed that staff are informed of quality issues and this was confirmed by staff spoken with. Family surveys are completed annually and results from the last survey show a high degree of satisfaction with the services being provided. Two areas for improvement from the survey have been identified and actions were undertaken.</p> <p>Policy development, review and document control is undertaken by the clinical quality and compliance manager and covers all necessary aspects of the service and contractual requirements. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents by delegated staff members at each facility. A few policies were identified as being past their review date and the clinical quality and compliance manager was able to provide evidence that these are under review and out for discussion, this included health and safety and restraint minimisation. Staff are updated on new policies or changes to policies through 'Time Target' (staff electronic time in and out system), notices and at staff meetings. This was confirmed by staff spoken with.</p> <p>The clinical quality and compliance manager and facility manager provided evidence via the organisational strategic plan of the identification and mitigation of strategic risks. These are reviewed</p>
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		<p>annually as part of the review of the document. The clinical manager undertakes the role of health and safety officer and has undertaken training relevant to the position, including in the Health and Safety at Work Act (2015). They described the processes for the identification, monitoring and reporting of risks and hazards and the development of mitigation strategies. The hazard register shows consistent review and updating of hazards as required and an annual review of the full register. New hazards are added to the register as requirements. Anglican Care Waiapu has been assessed by Accident Compensation Corporation (ACC) Partnership Programme as meeting tertiary level compliance.</p> <p>HLL have a corporate quality and risk management plan which includes an audit schedule, clinical indicators and policies and procedures that meet the requirements of the standard and contract requirements. They plan to review the current Anglican Care Waiapu plans and work towards a combination of both processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident form. This was confirmed by staff during interview and include the prompt reporting of incidents to the registered nurse or team leader on duty. The completed form is then sent to the quality coordinator for follow up including investigation. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. There have been no coronial enquires or police investigations. One Health and Disability Commissioner compliant has been open since July 2015 and a result is awaited from the Commissioner's office.</p> <p>Adverse event data is collated and analysed, including by type and resident, then reported weekly at the clinical team meeting with a monthly report to the clinical quality and compliance manager and the facility manager. Minutes of the health and safety, quality and risk meeting reviewed showed discussion in relation to trends, action plans and improvements made.</p> <p>The facility manager and clinical quality and compliance manager are aware of their requirements to report to external agencies and were able to give examples of reporting to the Ministry.</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>	<p>FA</p>	<p>Policies and procedures reviewed are in line with good employment practice and relevant legislation, and guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. This process was confirmed by the facility manager. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>The quality coordinator and clinical manager provided evidence of role specific orientation workbooks that includes all necessary components relevant to legislation, the standards, contract requirements and good practice. The orientation has work books specifically on behaviour management and how to document this and staff are also shown a DVD as part of the orientation. The organisation should consider adding a list to the organisational orientation checklist to document that these additional activities have occurred. They have also developed a refresher course for staff whom they have identified are not performing as expected and require a repeat of orientation Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>The clinical quality and compliance manager confirmed that continuing education is planned on an annual basis. The clinical nurse manager and quality coordinator provided evidence of the organisation wide compulsory training which includes six monthly fire and emergency evacuation and annual training on the Code of Rights, health and safety, restraint, manual handling, infection control, cultural safety, documentation, pressure injury, prevention and management and medications. Additional training also includes end of life care, pain management, the aging process and continence management. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the</p>

		<p>provider's agreement with the DHB. Staff who work in the kitchen have completed food handling courses and one cleaner has undertaken their cleaning certificate. The organisation has plans to work with Careerforce to include the other cleaning staff. The quality coordinator is a Careerforce internal assessor for the programme. Education records reviewed demonstrated completion of the required training, including palliative care courses and use of pump syringe drivers. Staff interviewed confirmed continuing requirements to attend training. There is an annual appraisal process for staff.</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>There is a documented policy on staffing mix that covers the contract requirements and includes the rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The clinical nurse manager is responsible for the rostering of staff. There is a six week rolling roster with set duties for staff. There is a casual pool of 12 staff. The minimum number of staff is provided during the night shift and consists of one registered nurse and a caregiver in each of the three wings.</p> <p>The provider has a contract with the DHB to provide a transitional service for people who require transition into dementia services and have proved difficult to manage in other facilities or at home. The contract allows for one-on-one staffing for these residents and this is managed with assistance of staff from an agency. There is a roster of senior staff who are on call; the facility manager, clinical nurse manager and the registered nurses. The RN on duty is able to gain support and advice from the emergency department of the DHB if required. The review of the roster cycle sampled over four weeks confirmed adequate staff cover has been provided.</p> <p>Family interviewed and observation during the audit confirmed that staff are providing services required of them.</p> <p>The quality and compliance manager for the prospective provider stated that the staffing ratios will be maintained for this service.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographics, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes included. Records were legible with the name and designation of the person making the entry identifiable. Administration staff maintain the resident register.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<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>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the clinical manager. They are also provided with written information about the services and the admission process. The service operates a waiting list for entry. The organisation seeks updated information from the HBDHB and the GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service facilitates transfer of residents to and from acute care services. There is open communication between all services, appropriate information, including the medication records and previous x-rays is provided for the ongoing management of the resident. All referrals are documented in the progress notes and a copy of the referral letter is placed in the integrated records for the</p>

		<p>individual resident. An example was provided by the locum GP when comments were made about the psycho-geriatrician visiting this facility to review the residents rather than taking the resident to the DHB. Family are kept informed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medication management in line with the Medication Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medications are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly and as needed.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked weekly by the pharmacist and a registered nurse for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for as required (pro-re-nata (PRN)) medicines met. The registered nurses monitor PRN usage and advise the GP as required for an individual resident.</p> <p>There are no residents who self-administer medications. There is a process for comprehensive analysis of any medication errors, and compliance with this process if verified.</p>

		No standing orders were in use during the audit.
<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>The food service is provided on site by employed staff and is in line with recognised nutritional guidelines for older people. A cook has been in this position for seven years and the kitchen hand interviewed for four years. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at the time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has an approved food safety plan and additional cleaning schedules are followed daily for chores to be completed. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. The cook and kitchen hands have completed safe food handling training every two years.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, and special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the dementia unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of satisfaction with meals is verified by family/whānau interviews and some responses from satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining room at meal times to ensure assistance is available to residents as needed.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for</p>

		reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Due to the nature of this service this rarely occurs. The transitional service unit is working effectively and the service provider, the NASC service and the DHB all work collaboratively together for each individual resident accessing the service.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as the interRAI assessment. In addition and as required, other assessment tools are readily available to utilise, such as skin integrity assessment, Norton scale risk assessment, nutritional screening, pain scale, Coombes falls assessment and a continence assessment. Other tools are available if needed as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the trained registered nurses. The RN in the dementia service of 20 residents has completed all interRAI assessments for this area of the service. The remaining RNs have completed the remaining residents' interRAI assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's

<p>to meet their assessed needs and desired outcomes.</p>		<p>individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is managed effectively. Care staff confirmed that care is provided as outline in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents` needs.</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 activities programme is provided by three activities coordinators. One is responsible for the programme implementation. One coordinator has nearly completed the New Zealand Society of Diversional Therapy Training (NZSDT). The activities coordinators provide the programme for the residents in the three different secure wings of the facility.</p> <p>A social assessment and history is undertaken on admission to ascertain residents` needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident`s activity needs are evaluated six monthly or more often if required.</p> <p>The planned monthly activities programme reviewed matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual, group activities and regular events are offered. The resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and enjoyable. A recent midwinter Christmas lunch was enjoyed by family/whānau and residents.</p> <p>The `twenty four hour wheel` is used for the dementia residents and activities are planned and available over this time. Activities are offered at the times when residents are most physically active and/or restless. This system has resulted in reducing need for medication, improved appetites, improved sleep patterns and settling times.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for wound care, continence review and falls management and evaluated at the clinically indicated timeframe stated on the plan (eg, daily or weekly) and according to the degree of risk noted during the assessment process. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting 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>	<p>FA</p>	<p>Residents are supported to access referral to other health and disability service providers. Although the service has a 'house' doctor, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' records, including to radiology, mental health services, health services for older persons, the DHB NASC service, dietitians or other health professionals.</p> <p>Referrals are followed up on a regular basis by the registered nurse or the GP. The family are kept informed of the referral process, as verified by documentation and family interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances were in place, including segregation of waste, recycling and detailing procedures for blood and bodily fluids management and disposal.</p> <p>Chemicals were seen stored in locked areas around the facility. Appropriate staff have undertaken training in chemical management.</p> <p>An external company is contracted to supply and manage the majority of</p>

		<p>chemicals used for cleaning and in the laundry. The company provide relevant training for staff and a monthly report, a sample of which was sighted. Material safety data sheets were available for the chemicals provided by the external company and these are stored safely. Staff interviewed knew what to do should any chemical spill/event occur and state they would report any related incidents in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, masks, face shields and plastic aprons.</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>	<p>FA</p>	<p>A current building warrant of fitness expires February 2017 and is displayed in the reception area. There is a proactive maintenance programme and reactive maintenance is by the use of a diary in each area to log maintenance issues. The testing and tagging of equipment is undertaken annually. The calibration of bio medical equipment is due for renewal and the organization has previously used the DHB, however, they have been informed that they no longer do this for community organisations. A private company has been engaged and have given the organisation a date to undertake this which will mean the equipment will be out of date for a short period.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and this was observed during the audit. The 'handyman' undertakes regular monitoring of the hot water temperature which shows this is being maintained at the required temperature for residents' safety.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned. Family members interviewed and the family satisfaction surveys results show that they are happy with the environment.</p> <p>There is a large area of vacant land adjacent to the facility that is owned by the organisation, no plans have been drawn up for this area but ideas</p>

		have been put forward for expansion and / or office spaces. The prospective provider has no plans to make changes to the present environment of this facility.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of toilet and showers facilities. This includes rooms with ensembles, and communal toilets and showers. An adequate number of accessible bathrooms and toilets are identified throughout the facility. Staff and visitor toilets are available and are separate from residents' toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. There is one communal block which contains two toilets and showers which could compromise residents' privacy (see CAR 1.1.3.1).</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single and were observed to be personalised for each resident by family and staff. Some have their own furnishings, photos and other personal items displayed. Rooms are of a size which allow for ease of movement and adequate personal space is provided to allow residents and staff to move around within the bedrooms safely including with the use of mobility aids.</p> <p>There are areas for the safe storage of mobility aids such as walking frames, hoists and wheel chairs. Staff reported the adequacy of bedrooms.</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>A number of communal areas are available in each wing for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry, this includes resident's personal items. Some family members undertake some of</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>their relative's laundry and this is facilitated by staff. Family members interviewed reported the laundry is managed well. The laundry is currently managed by dedicated laundry staff, some of whom undertake cleaning and kitchen duties. The processes were observed and seen to meet good practice. Laundry staff were able to demonstrate that they follow procedures on washing and drying cycles, dirty/clean flow, handling of soiled linen and have been given training on chemical management.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in the sluice rooms which are lockable, on cleaning trolleys which cleaning staff do not leave out of their sight. All containers were labelled with the manufacturers labels. Cleaning and laundry processes are monitored through the internal audit programme and by the chemical company representatives.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergencies. The facility has a good working relationship with the DHB including for emergency preparedness. The current fire evacuation plan was approved by the New Zealand Fire Service in 2014. Trial evacuations takes place six-monthly and a record is kept of which staff attend to ensure all staff attend one practice annually. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents.</p> <p>Call bells alert staff to residents requiring assistance. The response time can be audited if an issue is identified.</p> <p>The facility is a secure unit and access is by swipe card. Staff have access to areas depending on their role within the organisation. External lighting is in place around the facility, staff are advised to go to their cars in pairs or have another staff watch them go to access their cars safely.</p>

		If staff have concerns they are to call the police.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All residents' rooms and communal areas have opening external windows. Heating is provided by gas fired heating through the roof space and heat pumps in some areas. The temperature of the facility is monitored. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from senior staff in the organisation. The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical manager who reports to the organisation`s head office.</p> <p>Infection prevention and control signage is available such as `wash your hands` and/or `If you are unwell do not visit residents in the home`. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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	A new graduate registered nurse (previously an enrolled nurse) has recently taken on the role of infection control coordinator (ICC). They have appropriate skills, knowledge and qualifications for the role. The ICC works closely with the clinical nurse manager. The ICC has attended the ICC quarterly meetings held at the DHB with the IPC Nurse Specialist. Well established local networks with the infection control team at the DHB are available and expert advice from the community

		<p>laboratory is available if additional support and information is required. The ICC has access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2015 and include appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitises, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Handwashing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection prevention and control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak has occurred, there is evidence that additional education has been provided in response. A recent outbreak occurred and the service was closed. The HBDHB was notified of the closure. Infection control stores are kept in each unit in preparedness for an emergency and the cupboard is clearly labelled `Infection Control and Emergency Care`. A summary report for a recent outbreak was reviewed and demonstrated a thorough process for investigation and follow-up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> <p>Education with residents is generally on a one on one basis and has included hand washing advice.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommend for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the infection register. The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced from the organisation's head office and comparisons/benchmarking is done with other like services in the organisation. Benchmarking externally provided assurance that infection rates in the facility are below average for the sector.</p> <p>New infections and required management plans are discussed at handover, to ensure early intervention occurs. Surveillance results are also shared with staff at the quality meetings, as confirmed in meeting minutes sighted and interviews with staff.</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>The facility follows the suite of policies and procedures developed by Anglican Care Waiapu and these are currently under review. These meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical coordinator is the restraint coordinator.</p> <p>On the day of audit, 20 residents were using restraints. The restraint coordinator stated that they do not use enablers as the residents are unable to give consent for their use. There is documented evidence in all files reviewed (four) of family members with Enduring Power of Attorney (EPOA) giving consent for the use of restraint.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with the restraint coordinator.</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>The restraint approval group, is made up of the clinical coordinator, CNM, quality coordinator, facility manager, registered nurse and members of the health and safety group. The group are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of meeting minutes, review of residents' files and interview with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family who have Enduring Power of Attorney (EPoA) involvement in the decision making, as is required by the organisation's policies and procedures, was on the restraint consent form in each resident's file where restraint is in use. The lifestyle care plan includes documented restraint use and risks associated with the use of these.</p> <p>The CNM and restraint coordinator were able to give examples of residents who have been admitted from other facilities and have had restraint identified in their transfer documentation and following transitional processes have ceased to require them at Colwyn House. The facility should consider documenting these as an ongoing quality activity.</p>
<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>	<p>FA</p>	<p>Assessments for the use of restraint is documented on an assessment form that included all requirements of the Standard. The initial assessment is undertaken by a registered nurse with the sign off by the restraint minimisation group, with input from the resident's family with EPoA. The restraint coordinator described the documented process. The GP signs off the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint and all signed appropriately within a tight timeframe</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint monitoring forms are used to record each episode of restraint use. When restraints are in use, hourly monitoring occurs to ensure the resident cares are being met with recording of toileting, food and drink being given and that the resident remains safe. The monitoring form is kept in the resident's file and used by the restraint coordinator for monitoring of the usage and conformity to policy. This was seen completed in four of four residents' files where restraint is in use. Residents were observed with the use of bed rails and modified lap belts in use and it was seen that all processes ensure dignity and privacy being maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and was last updated in July due to the August meeting having been cancelled.</p> <p>The safe use of restraint has been highlighted by a serious incident and this has resulted in changes to practice to ensure staff have the knowledge to ensure this occurs. Staff have received training in the organisation's policy and procedures and in the safe application of restraint, as well as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files (four) evidenced the individual use of restraints is reviewed and evaluated monthly by the restraint group, three monthly as part of the lifestyle care plan and interRAI reviews, with input from family, where ever possible, and documented evaluations by the GP.</p> <p>The evaluation includes all requirements of the Standard, and in some cases, future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their</p>	<p>FA</p>	<p>The restraint committee review all restraint use on a monthly basis, which includes all the requirements of this Standard. Minutes of the</p>

use of restraint.		restraint group meeting confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and the appropriateness of restraints. Restraint use is reported to the quality meetings and is an item on the staff meeting agenda. Any changes to policies, guidelines, education and processes are implemented if indicated. The CNM stated that the use of restraint has been reduced over the last year, as noted in the report to the clinical quality and compliance manager.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>Eight complaints have been received this year with some from staff as well as resident family members. The complaints register had no area for recording that acknowledgement of the complaint had occurred. In reviewing the actual complaint documentation there was evidence of some being acknowledged by return email, however four out of eight complaints did not have documented evidence of an acknowledgement letter or response being sent within the five days required by the Code. This was confirmed by the facility manager. The clinical quality and compliance manager provided a draft acknowledgement letter which will be used for future complaints prior to the end of the audit and a change was made to the register to allow for the recording of sending</p>	<p>Four out of eight complaints received this year did not have an acknowledgement letter sent.</p>	<p>All complaints are followed up by a letter to the complainant acknowledging the complaint within the timeframes of the Code of Rights.</p> <p>180 days</p>

		of acknowledgement.		
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	<p>In the Matai wing there is an ablution block of two toilets and two showers which share the same entry point from the corridor. There are doors to the two toilets but only curtains to the shower cubicles. There is no private area for resident's to be dried and dressed after showering, no means to stop other residents using the toilets while showering occurs. The clinical manager (CM) and facility manager decommissioned one of the showers during the audit and a more substantial shower curtain was put in place. A means to address the entry of other residents to this area while showering occurs is to be looked at.</p>	<p>The ablution block in the Matai wing allows entry to two toilets and two shower cubicles. Although there are doors on the toilets there is only curtains to the shower cubicles. There is no means of ensuring privacy of residents using the two shower cubicles while being dried and dressed and no way of preventing other residents entering to use the toilets.</p>	<p>Residents' privacy is maintained during the showering process in the ablution block in Matai wing.</p> <p>180 days</p>

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
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful</p>	CI	<p>A project has been undertaken following an incident and a complaint from a family member about a resident who sustained a fracture following a fall. Investigation of the number of falls occurring for residents who had restraint to prevent such injuries was undertaken, this included investigation of the restraint process including, how staff were putting on the restraint lap belts. The quality co-ordinator undertook research on the use and application of lap belts. This resulted in the development of a booklet on the step by step process to be used as part of staff training on the application of the restraint. This has now been added to the annual competency requirements and all care givers are to be signed off by a RN. The restraint coordinator also spoke of working with the manufacturer of lap belts to stop them from</p>	<p>Following a serious injury of a resident which resulted in a fracture, in April 2015 it was identified that there had been five incidents of falls for residents over an eight month period, who had restraints in use. Research has provided staff with the knowledge of how to safely apply the restraint and a new education process has been put in place to ensure all care givers are competent to apply restraints. This has resulted in a marked reduction in incidents with only one incident being reported since this process has been put in place.</p>

initiation; (e) When adequate resources are assembled to ensure safe initiation.		sliding down and causing possible harm and also being more dignified for the residents. This has resulted in a reduction in the number of incidents related to the application of restraints.	
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End of the report.