

Y&P NZ Limited - Deverton House Rest Home

Introduction

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

The audit has been conducted by 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:	Y&P NZ Limited
Premises audited:	Deverton House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 September 2016 End date: 21 September 2016
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	17

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

Deverton House Rest Home provides rest home services for up to 21 residents. On the day of audit there were 17 residents receiving care. The majority of residents do not speak English. The facility manager commenced in the role in November 2015 and is responsible for managing the service with the assistance of the registered nurse. The registered nurse was employed in December 2015. All the residents and family members interviewed spoke very positively about the staff, personalised care and the standard of services received.

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 a review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management and staff.

This audit identified that improvements are required in three areas relating to reviewing the hazard register, medicine competency assessment and providing training to staff on restraint minimisation and the use of enablers.

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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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. An interpreter was used for all interviews, as for all but three residents, English is their second language.

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

There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's vision, values and mission are documented in the business and continuity plan. There is also a documented quality and risk plan. The facility manager is on site weekdays and is otherwise on call. The owner is also on site most days. The facility manager has attended more than eight hours of education on managing a residential care service as required to meet the providers' contract with Waitakere District Health Board (WDHB).

The quality programme includes compliments, complaints management, incident reporting and policy and procedure review. The quality and risk programme has been developed by an external consultant and personalised to reflect the needs of Deverton House Rest Home. Policies are current and available to staff. The facility manager is responsible for document control processes. There is a risk management plan and organisation risks are being identified, managed and reviewed. Whilst new hazards are being reported, the hazard register has not been reviewed since November 2015. Internal audits and surveys are conducted. Where improvements are required following quality activities this occurs in a planned manner. The facility manager and the registered nurse are aware of the events that require essential notification. Regular resident and staff meetings occur.

Staff recruitment includes the applicant completing a job application. Reference and police checks are conducted. Annual performance appraisals have been completed for applicable staff. An orientation programme is in place for new employees and records of this are maintained. Staff have access to relevant ongoing education.

The staffing and skill mix requirements are implemented to ensure the residents' care needs are met. The requirements align with the provider's contract with Waitakere DHB. A staff member with a current first aid certificate is rostered on each duty. The registered nurse is normally on site three days a week and is available by telephone when not on site. The owner is also available to staff when not on site.

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

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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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.

Services are provided by suitably qualified and trained staff to meet the needs of residents. The registered nurse is supported by care and allied health staff (eg, a podiatrist and a pharmacist) and a designated general medical practitioner. Shift handovers support continuity of care.

Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. After a full comprehensive assessment, the long term care plan is developed and implemented. Short term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis.

Residents and families interviewed reported being well informed and involved in the care planning process, including evaluation, and that care is provided is of a high standard. Residents are referred to other health providers as required, with verbal and written handovers.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice, and consistently implemented using an electronic system. Medicines are administered by senior care staff, 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. The service has a four-week summer/winter rotating menu which is approved by a registered dietitian. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

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.		Standards applicable to this service fully attained.
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Policies and procedures are available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment are readily available for staff use.

The building has a current building warrant of fitness. Clinical equipment in use has a current calibration. Electrical safety checks of electrical appliances are current. The security arrangements and practices are appropriate and includes surveillance cameras monitoring communal areas and the entrance.

There are 21 single occupancy bedrooms. All have an ensuite toilet and hand washing facilities. There are two showers and one other toilet for resident use. Call bells were present in the bedrooms and bathrooms. Residents advise their personal space was sufficient, including those who required staff assistance or the use of mobility devices. There are two lounges, a separate dining room and hair salon area. There is good indoor/outdoor flow with a deck and garden areas for the residents and their families to use. The facility has adequate heating and ventilation. Smoking is allowed only in a designated area.

Cleaning and laundry services are provided by employed staff. These services are monitored through the internal audit programme and resident satisfaction survey process. Residents and family members interviewed confirmed the facility is kept clean, ventilated and warm.

Emergency policies and procedures provide guidance for staff in the management of emergencies. There is an approved fire evacuation plan and fire evacuations drills are conducted at least six monthly. There are sufficient supplies available on site for use in the event of emergency or an infection outbreak.

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.		Some standards applicable to this service partially attained and of low risk.
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The service has a commitment to a `non-restraint policy and philosophy`. The restraint minimisation and safe practice policy complies with the standard. There was no restraint in use at the time of the audit. Two residents had enablers in use. The enablers are voluntary and aid independence. Written consents were on each resident's file. There are six monthly reviews occurring to ensure the use of enablers is voluntary and safe. Training for staff on restraint minimisation and the use of enablers has not occurred in 2015 and 2016 to date.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by the registered nurse 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, microbiologist, and the general practitioner as required. The programme is reviewed annually.

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

Aged care specific surveillance is undertaken, analysed, trended and benchmarked and results reported and fed back to staff at the staff meetings. Follow-up action is taken 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	42	0	3	0	0	0
Criteria	0	90	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Care staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training is included as part of the induction process for all new staff and is ongoing, as was verified in the 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>A detailed informed consent policy is in place. The service ensures informed consent is part of all care plans and contact with families. Every resident has the choice to receive services, refuse services and withdraw consent for services. If a resident is cognitively alert they will decide on their own care and treatments unless they indicate they want representation. Informed consent is closely linked with the Residents` Code of Rights and Responsibilities.</p> <p>The service provider ensures residents/family/enduring power of attorney (EPOA) understand documents that they are signing when English is their second language. The informed consent forms, resuscitation authorisation and advance care instructions, and flu vaccine consent sighted are available in English, Cantonese and Mandarin. The caregivers interviewed demonstrated their ability to provided information that residents required in order for the residents to be actively involved in their care and decision-making. Staff</p>

		interviewed acknowledge the resident's right to make choices based on information presented to them.
<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, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Nationwide Advocacy Service were displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with the assistance of an interpreter 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 education was provided as evidenced in the education plan and staff records reviewed.</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 outings, activities and entertainment. Visitors are welcome and the facility has unrestricted visiting hours. 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>	FA	<p>The complaints policy detailed the residents or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint is documented and the timeframes aligned with the requirements of the Code.</p> <p>The facility manager and the owner advised there have been no complaints received from the Health and Disability Commissioner (HDC) or Ministry of Health (MOH) since the last audit. A complaint received via the District Health Board (DHB) in 2015 has now been closed. A complaints register is being maintained. A review of the complaints documentation verified the complaints have been investigated and responded to in a timely manner.</p> <p>All the residents and family members interviewed confirmed being aware of the complaints process. The residents and family identified they were happy with the services provided.</p> <p>The staff interviewed were able to detail their responsibilities in the event a resident made a complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	FA	<p>Residents interviewed with assistance of an interpreter report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy service) through the facility manager as part of</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>the admission information provided and discussion with the registered nurse on admission. The Code is displayed in the entrance way together with information on advocacy services and how to make a complaint feedback forms. A suggestion box is also available in the entranceway.</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>	<p>FA</p>	<p>Residents and families interviewed confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Families reported there was always a positive atmosphere when they visit.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring residents information is held securely and privately). Any exchange of verbal information is managed so that others cannot hear. All residents have their own rooms. There is one married couple who share a bedroom and the other room allocated is used as a lounge to share during the day. This works effectively for this couple and they are pleased with this arrangement.</p> <p>Residents are encouraged to maintain their independence by going on outings with family in the community, shopping trips, community activities and attending activities of their choice. Each service plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual culture, 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 the signs and symptoms, and what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for all new staff, and is then provided annually, as confirmed in the 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>	<p>FA</p>	<p>The policies reviewed acknowledge the organisation's responsibilities to Maori residents in accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers are part of the organisation's objectives which are documented in the Maori Health Plan.</p> <p>There are no residents who identify as Maori at the time of audit. The caregivers interviewed demonstrated good understanding of services that are in line with the needs of Maori residents and importance of whanau.</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>Residents verified, with the assistance of an interpreter, that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, requiring interventions and special needs were included in all care plans reviewed.</p> <p>Staff reported they received training in cultural awareness and this was evidenced in the education plan.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The general practitioner locum interviewed also expressed satisfaction with the standard of services provided to residents.</p> <p>The staff records reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. The family and residents reported they are happy with the care provided. The registered nurse interviewed has completed the New Zealand Nursing Council professional boundaries workshop which is mandatory for obtaining an annual practising certificate.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from a quality consultant and allied health professionals, such as the gerontology nurse specialist from the DHB, and services for older people who visits regularly. The registered nurse has completed additional training at the DHB to improve practice and to understand geriatric nursing.</p> <p>The general practitioner confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive in-service education on a regular basis. The RN and assistant manager interviewed stated that the support of management was appreciated for external education opportunities to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<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 residents' records reviewed. There was also evidence of resident/family input</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> <p>Interpreter services were used for this audit. Interpreter services are available and accessible via the DHB if and when required. Staff knew how to do so, although reported this was rarely required due to staff being able to provide interpretation as and when needed, and the use of family members. For most residents in this home, English is not their first language (only three residents speak English).</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>Deverton House Rest Home has a documented mission statement and philosophy on care that is focused around the provision of individualised, resident focused care that maximises independence. The facility manager monitors the progress in achieving these goals via the internal audit process, review of resident and family satisfaction at three monthly service review meetings. The facility manager has an 'open door' for residents and families. A number of goals/objectives are set for the forthcoming year and these are monitored and documented once completed.</p> <p>The day to day operations and ensuring the wellbeing of residents is the responsibility of the facility manager. The current owners have owned this rest home for over four years. The owners also own and operate another rest home in central Auckland. The owners are on site most days and are also available to speak with residents and family members.</p> <p>A facility manager was initially employed in October 2014 in another role and subsequently appointed as facility manager in October 2015. The facility manager participates in relevant ongoing education as required to meet the provider's contract with WDHB. The facility manager has completed a New Zealand industry approved qualification in age related care and has worked as an English language teacher overseas for ten years before moving to New Zealand.</p> <p>The registered nurse commenced employment at Deverton House Rest Home in December 2015 and is on site three days a week (approximately 30 hours a week). The RN also works in the owner's other rest home. The RN is on call when not on site and is responsible for the clinical services provided.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in</p>	<p>FA</p>	<p>The residential care officer (RCO) is responsible for oversight of services in the facility manager's absence and is on site weekdays. The residential care officer started working at Deverton House Rest Home in January 2015. The RCO trained as a registered nurse overseas, but does not have New Zealand registration. She has a diploma in healthcare management via a New Zealand training facility and the certificate of completion was sighted. The residential care officer is supported by the registered nurse and the facility owner's as required. The RCO is able to detail what the roles and responsibilities are in the facility manager's absence and these</p>

<p>an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>aligned with the facility manager's expectations of 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>	<p>PA Low</p>	<p>There is a documented quality and risk plan and this was sighted.</p> <p>Policies and procedures are available to guide staff practice. The policies are developed by an external consultant and then reviewed and localised to reflect Deverton House Rest Home by the facility manager and the RN. Changes in policy are discussed at staff meetings as verified by staff interviewed and referenced in applicable meeting minutes. As an example, the staff meeting in January 2016 included discussions on the changes made to the vital signs monitoring policy. Document control processes are implemented and out of date policies are archived.</p> <p>A review of the quality and risk programme is undertaken three monthly via the service review meetings. The minutes of the last three meetings were reviewed and included discussions on individual resident's needs, complaints and compliments, changes to policies/procedures/practices, the results of audits, staffing, education, the use of restraint, infection data and the number and type of reported incidents and quality related trends. The management team and the owner have an 'open door' to staff and residents/families.</p> <p>Internal audits have been undertaken and are conducted using template audit forms. A schedule details what audits are to be undertaken and when. The eight audits sampled during audit identified there is good compliance by staff in meeting the requirements of the organisation's policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored. Short term care plans are utilised to document follow-up for applicable incidents.</p> <p>A resident satisfaction survey was conducted in March 2016. The majority of residents' participated. The feedback is predominantly positive about the services provided. Staff have responded to any individual specific requests / comments made by residents.</p> <p>Resident meetings are held every month. Minutes sighted reflected discussion on food, the activities programme, staff, laundry services and facility cleanliness. Resident compliments were recorded and communicated to staff. Education has been provided to residents on infection prevention and control topics during the resident meetings.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The facility manager and the RN were able to discuss changes in organisation risk. Whilst new hazards are being reported, the hazard register was dated as last reviewed in January 2015.</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>Policy and procedure details the required process for reporting incidents and accidents. Different template forms are used by staff to report events including infections, episodes of challenging behaviour, medicine related events and incidents and accidents. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme and as discussions at staff meetings.</p> <p>Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This is verified by resident and family members interviewed with the assistance of an independent translator who confirmed they are kept informed. The incident form includes an area to record that family were informed, and who else was notified about the reported event (eg, where applicable the RN, and the resident's GP). A summary of the number and type of reported events is maintained in each resident's clinical records. A review of at least seven reported events demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident's care plan where applicable or a short term care plan developed. Staff communicated incidents and events to oncoming staff via the shift handover. Individual events are discussed with staff monthly at the staff meeting and also reviewed at the service review meetings that are held three monthly. The number of incidents is benchmarked monthly with other aged care facilities and this process and the subsequent reports were sighted. Themes and trends over time are monitored and evaluated. The number of medicine related events has reduced since the rest home moved to an electronic medicine management system at the end of 2015.</p> <p>The facility manager, residential care officer and the RN are able to identify the type of events that must be reported to external agencies. This includes the admission and discharge of any resident. An essential notification was made in October 2015 to HealthCert about the change in the person holding the facility manager role. A copy of this communication and subsequent acknowledgement was sighted.</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>The copy of the annual practising certificates (APCs) for the two general practitioners (GPs), podiatrist, three pharmacists, and the two registered nurses (RNs) including the relief RN are current.</p> <p>The recruitment/employment policy aligns with current accepted practices. This includes staff completing an application form and completing a health declaration, police vetting, interviews being conducted and reference checks obtained and retained. Staff have a signed employment agreement and confidentiality/privacy agreement on file. Performance appraisals are conducted at least annually and these were sighted in relevant staff files.</p> <p>Records evidencing completion of the orientation programme were present in staff files. Staff interviewed report the orientation included between two and three shifts being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident's care needs.</p>

		<p>Individual records of education are maintained for each staff member and copies of education certificates are present in the staff files reviewed. In-service education and attendance records were sighted showing staff had access to regular ongoing education relevant to their roles and the service, excluding restraint minimisation and use of enablers (refer to 2.1.1.4). There was good attendance from staff at the in-service education sessions provided by external health professionals as well as employees.</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>	FA	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with Waitemata District Health Board (WDHB).</p> <p>The current roster was reviewed and demonstrated that there is at least one senior caregiver on each shift. A junior caregiver is rostered to assist with busy periods in the morning and the afternoon/evening. The facility manager and residential care officer are on site weekdays between 9 am to 5pm. They assist with caregiving as required and the facility manager also facilitates the activities programme. The two owners also come on site most days and assist taking residents to appointments, taking the residents on outings and undertaking gardening / maintenance activities.</p> <p>The RNs is on site at least three days a week for approximately 28-30 hours, and also works in the other rest home owned by the Deverton House Rest Home owners. The RN and the facility manager is on call when not on site.</p> <p>Additional staff hours are rostered for the kitchen service (6.30 am to 2pm) every day, and cleaning services (four and a half hours each week day). Another staff member provides the laundry services with designated time daily.</p> <p>All caregivers interviewed report that there is adequate staff available and that they are able to get through their work. The staff confirmed the RN and the facility manager is available out of hours if required. All staff members, managers and the owners have a current first aid certificate and these were sighted.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on all records reviewed as the unique identifier. All necessary demographic, personal, clinical and health information was fully completed in the residents' records randomly sampled for review. Clinical notes were current and integrated with GP and allied health professional notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private information was on public display during the</p>

accessible when required.		audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has an admission/enquiry form that records the pre-admission information. There is a resident's welcome brochure for all enquiries. 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. The service provides rest home care and respite care only.</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. Records reviewed contained the information record, 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>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. A transfer/discharge summary is completed when facilitating a transfer from the rest home to acute care services, such as the DHB. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including a copy of the medication record (with any known allergies documented) is provided for the ongoing management of the resident. All referrals are documented in the progress records.</p> <p>One family interviewed had experienced their relative being transferred from the DHB to this facility and reported that they were kept informed before and during the transfer.</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>	PA Low	<p>The medication management policy and procedure has been updated and clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, processes when an error occurs as well as definitions for 'over the counter' medications that may be required by residents. The sighted policies meet the legislative requirements of best practice.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe medicine management was observed on the days of the audit. Medicines are locked away in a locked medicine cupboard and a medication trolley is used for the rest home medication round. Medicines that require refrigeration are stored in a separate fridge. Temperature monitoring of the fridge is completed and records were available.</p> <p>The medicine records randomly reviewed on the electronic system used have been reviewed by the GP at least three monthly. All prescriptions sighted were accurately documented by the GP and checked by the pharmacist. Any allergies/sensitivities are flagged on this system. There is a separate specimen signature</p>

		<p>register maintained for all staff who administer medicines. Resident photo identification is on all individual resident's records reviewed.</p> <p>No residents are self-administering medications. There is a three monthly risk assessment for a resident if authorised by the GP to administer their own medications.</p> <p>There are documented competencies for care staff designated to administer medicines. There is an improvement required in relation to the RN competency. The registered nurse had a completed medication competency, but this had not been completed by a registered health professional.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook who has worked at this facility for six months. The cook is assisted by a kitchen hand. The menu follows four-week summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of production, preparation, storage and disposal comply with current legislation and guidelines. The owner/director orders and purchases all food. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the food service planning. The cook has undertaken a safe food handling qualification and the kitchen hands have completed relevant food handling training. A residents' food satisfaction survey was completed 11 March 2016 and this showed that the variation of both Chinese and European meals was appreciated by the residents.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews and resident meeting minutes. 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 appropriate 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</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is full occupancy, 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 service offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whanau. This was discussed with the facility manager and the RN. There is a clause in a resident's access agreement related to when a resident's placement can be terminated.</p>

family/whānau is managed by the organisation, where appropriate.		
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 a recognised pain scale, falls risk, skin integrity, nutritional assessment and depression scale if and when needed. These tools are used when deficits are recognised. The sample of care plans reviewed had an integrated range of resident related information. All residents' records reviewed have a completed interRAI assessments completed by the one registered nurse who is fully trained as an assessor on site. A schedule has been developed by the RN for interRAI assessments on admission and for the six monthly reviews.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The residents' care plans 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 records, activities records, medical and allied health professional's entries clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of the individual care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. There is evidence of short term care plans for any event that is not part of the care plan. The short term care plans are used for wound care, weight loss or monitoring a resident after a fall. The service has adequate dressing and continence supplies to meet the needs of the residents. Observations on the day of audit indicated residents are receiving appropriate care to meet their individual needs. The RN discussed the care plans which are comprehensive. The gerontology nurse specialist is also available to assist the RN if required when reviewing the care plans. The caregivers interviewed reported that the care plans are accurate and are kept up-to-date and are able to be followed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The activities programme is developed and implemented by the facility manager who is completing the Careerforce diversional therapy course and is over half way through this training. A social assessment and history is undertaken on admission ('My Life') 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

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>monthly as part of the six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual group activities and one on one activities as needed. Examples included music sessions, bingo, Chinese/NZ TV channels programmes, skype, dog visits weekly, church visits and family events. The activities programme is discussed at the residents` meetings and minutes of the meetings are documented. Resident and family surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they were satisfied with the programme.</p> <p>An eight seater van is available for attending special events and outings in the community. Families are encouraged to attend activities.</p> <p>The families interviewed reported their relatives enjoyed the range and variety of activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents` records reviewed had a documented evaluation that is conducted within the past six months. Evaluations are resident focused and indicate the degree of achievement or response to support interventions and progress towards meeting the desired outcomes. If a resident is not responding to the interventions being delivered, or their health status changes, then this is discussed with the GP. Residents` changing needs are clearly described in the care plans reviewed.</p> <p>Short term care plans are used for wound care, pain, infections and/or changes in mobility, changes in food and fluid intake and skin care and/or pressure area care when needed.</p> <p>These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident`s progress records. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that these are identified at handover.</p> <p>The families reported that they can consult with staff and/or the GP if they have any concerns or there are changes in the resident`s condition. A family communication record was in the front of each resident`s record reviewed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service provider. Although the service has a resident GP, residents may choose to use another medical practitioner. If the need for non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of any referrals were sighted in residents` records, for example, referrals to radiology, skin clinic, dietitian, podiatrist, medical outpatients, out-patient eye clinic, geriatric specialist or gerontology nurse specialist at the</p>

<p>access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>DHB or in the community.</p> <p>The GP locum interviewed reported that appropriate referrals to other health and disability services are well managed at this service.</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>Policies were sighted to detail how waste was to be segregated and disposed. The policy content aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been provided with training on chemical safety and handling.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection. An emergency kit with PPE is also available in the staff office for use in an outbreak or other significant event. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment.</p> <p>Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system.</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>There is a current building warrant of fitness (BWOFF) with an expiry 27 July 2017. Ongoing checks to maintain the BWOFF are occurring. An external company undertakes performance monitoring and electrical safety checking (where applicable) of clinical equipment. Evidence of this were sighted with the exception of new equipment purchased in the last six months and the nebuliser machine which staff report is not used. Electrical equipment sighted has evidence of current electrical testing and tag checks. The gas heaters have been recently serviced. Maintenance requests are identified and documented during facility inspections. Requested tasks have been signed off as completed or are in progress. The hot water temperature is monitored monthly. The temperature is within required range (under 45 degrees Celsius) and this included hot water tested at three outlets during audit.</p> <p>Grab rails are present in the patient showers. There are handrails in the corridors. The bathroom floors have non slip linoleum floor covering.</p> <p>The residents and family members interviewed confirmed the facility is appropriately furnished to create a home like environment. Furniture and fixtures were appropriate to the service setting. The front entrance is at ground level. There are also exits at both sides the building where there are both stairs and ramps. Each</p>

		<p>resident bedroom has a door that opens onto a deck area. Staff advise these are not often used by residents. Residents have personalised their rooms as observed.</p> <p>The facility vehicle has a current registration and warrant of fitness.</p> <p>There is a number of external chairs on the deck and at the front entrance that residents and family can use. Staff identified these areas are used more by residents during the warmer months. Residents were observed to be mobilising independently or with the use of a mobility device in their bedrooms and in communal areas.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Hand basins and a toilet are present in each resident's ensuite bathroom. Waterless hand gel is also available for staff and residents at locations around the facility.</p> <p>There are two showers and a separate toilet near the front lounge that all residents are able to use. The caregivers interviewed confirm there are enough bathroom and shower facilities for the residents' use as they assist or provide supervision for residents when showering. Privacy locks are present on the bathroom and shower doors that are accessible / utilised by all residents.</p> <p>There are separate bathroom facilities for staff use.</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 residents' bedrooms are single occupancy. The rooms contain space for the residents, personal possessions and use of mobility devices if required. Residents were sighted mobilising inside the rest home independently, including while using a mobility aid.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided</p>	FA	<p>There are two lounges and separate dining area that residents and their family or visitors can use. The residents and family members interviewed confirmed that there is sufficient space available for residents and support persons to use in addition to the residents' bedrooms. There is also a designated area used as the hair salon. The hairdresser comes on site as required.</p>

<p>with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Policies and wall mounted posters detail how the cleaning and laundry services are to be provided. Resident's personal clothing is washed and returned daily.</p> <p>The residents and family members interviewed confirmed the rest home is normally kept clean and tidy and residents' laundry is washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated a high level of compliance with the rest home policy and service requirements and prompt remedial action where improvements were requested / identified. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services. The feedback from residents is predominantly positive. Chemicals are stored in designated secure cupboards. The wall mounted auto chemical dispenser is located in an additional bathroom which is not used by residents. The cleaner described the chemicals used for environmental cleaning during interview and these aligned with the wall mounted instructions. Instructions for managing emergency exposures to chemicals is readily available to staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 28 August 2012. A fire evacuation drill was conducted in both March and September 2016 and the records were sighted.</p> <p>Policy documents provide guidance for staff on responding to other events, including (but not limited to) earthquake, flooding and volcanic eruptions.</p> <p>A review of the staff files and training records verifies all staff have a current first aid certificate. The caregivers interviewed detailed their responsibilities in the event of emergency.</p> <p>There are sufficient supplies available of dated dry food, drinking water, lighting, a radio and batteries, and other clinical supplies for use in emergency. A gas hob for cooking is available along with spare blankets. The facility manager advises the food is regularly rotated through to the kitchen and replaced to ensure it remains of appropriate quality. Food items are dated when purchased.</p> <p>Call bells are present in the bathrooms and residents' bedrooms. They alert audibly and a light also illuminates outside the room. Three call bells tested at random were fully functioning. Staff were observed to answer the call bells promptly.</p> <p>The caregivers interviewed advise the external doors and windows are checked and locked prior to the</p>

		<p>evening meal being served. All external windows and doors are also checked and secured at this time. A door bell is present at the front entrance for family / visitors to ring after this time in order to gain access. A number of security cameras are in use monitoring the entrance and communal areas. The images display on a screen in the manager's office and are electronically archived for two weeks. The facility manager advises the archived images have been reviewed on one occasion to obtain additional information about a resident who had an unwitnessed fall.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms have a window and a door that opens directly onto the deck. There are wall mounted heaters present in each bedroom and in communal areas. Residents and family members interviewed verified the facility is kept suitably warm and ventilated. Smoking is only allowed in designated external areas. There are currently no residents who smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>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 the infection prevention and control team at the DHB as needed. The infection control programme and manual are reviewed annually.</p> <p>The 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 three monthly to the facility manager and tabled at the quality meeting. The committee includes the assistant manager, cleaner, kitchen staff, caregiver and the registered nurse.</p> <p>Signage at reception alerts visitors and staff that have been unwell to stay away from the residents. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate</p>	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for about one year. The RN has completed some training at the DHB in relation to infection control as verified in the training records sighted. The infection control team at the DHB is available and expert advice can be sought from the community laboratory and/or the GP. The coordinator has access to</p>

<p>human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control coordinator confirmed at interview 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>	<p>FA</p>	<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 June 2016 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable aprons and gloves, as appropriate to this rest home setting. Hand washing 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>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. The education planner for 2016 has been implemented. The registered nurse completes education sessions at the staff meetings when able. There is also an infection control online programme that staff are encouraged to participate in. All care staff and domestic staff are completing this course online. A record is maintained of all infection control education provided. The content of the training is documented and evaluated to ensure it is relevant, current and understood by the care staff.</p> <p>Education with residents is generally on a one-to-one basis and included mostly handwashing advice and skills.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility, with infection definitions reflecting a focus on symptoms rather than on laboratory results. This includes urinary tract infections, soft tissue, fungal, eye gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>identified a record of this is documented on the infection reporting form. The ICC reviews all reported infections. Three 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 at staff meetings and at staff handovers. Graphs are produced that identify trends and benchmarked externally against another facility with the same ownership. Benchmarking has provided assurance that infection rates in the facility are below average for the sector and the nature of this service.</p> <p>New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff. There have been no outbreaks of infection since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>Restraint is not used and enablers are voluntary. Staff training on restraint minimisation and the use of enablers has not occurred in 2015 or 2016 year to date.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>There is a business risk document which details a range of organisation risks including (but not limited to) those related to service delivery, the facility, equipment, finances, contractual issues and civil or other emergencies. The risk plan was initially developed by an external consultant and subsequently reviewed by the facility manager in January 2016. The risk register includes the strategies required to reduce identified risk.</p> <p>Staff are required to report new hazards and this is occurring. Recent examples include light bulbs that no longer worked, and the hazards addressed. There is no clear process for the ongoing review of the organisation’s hazard register. This is dated as last reviewed in</p>	While there is a process for identifying new hazards, the existing hazards and mitigation strategies as detailed in the hazard register have not been reviewed since January 2015.	<p>Implement a process to regularly review the organisation’s hazard register and the management of hazards.</p> <p>180 days</p>

		January 2015.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>The training records reviewed evidenced the caregivers have all completed current medication competencies with the registered nurse. The registered nurse interviewed is fully informed about the medication processes and is responsible for overseeing the medication management for the residents at this facility. The staff record review evidenced that the registered nurse also had a copy of a completed medication competency on file, however, this had not been completed by a registered health professional.</p>	<p>The registered nurse's medicine competency was not completed by a registered health professional.</p>	<p>Ensure the registered nurse is deemed competent for medicine management by another registered nurse or by the DHB gerontology nurse specialist who visits the facility on a regular basis.</p> <p>180 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	<p>The service has a commitment to a 'non-restraint policy and philosophy'. The restraint minimisation and safe practice policy complies with the standard. There was no restraint in use at the time of the audit. Two residents have enablers (bed loops) in use to aid mobility and independence. An enabler register is maintained.</p> <p>Some staff interviewed had a good understanding that the use of enablers was a voluntary process along with approval and informed consent processes. Other caregivers were not sure. Signed consent forms are on file for both residents with enablers in use. The</p>	<p>Education on safe and effective alternatives to restraint and the use of enablers is not included in the orientation programme or ongoing education programme for staff (in 2015 and 2016 year</p>	<p>Ensure staff are provided with training on restraint minimisation and the use of enablers.</p> <p>180 days</p>

		<p>residents' care plans detail the use of enablers. Review of enablers has historically occurred on a monthly basis, however, is now occurring six monthly to align with the care plan reviews. Review of enablers in use verified that these are being used appropriately and safely.</p> <p>Education on safe restraint minimisation and the use of enablers is not explicitly included in the orientation programme or ongoing education programme in 2015 and 2016 year to date.</p>	<p>to date).</p>	
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.