

Heritage Lifecare Limited - Te Wiremu 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: Te Wiremu House

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

Dates of audit: Start date: 11 October 2016 End date: 12 October 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: 77

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

Te Wiremu House provides dementia/medical, rest home and hospital level care for up to 94 residents. The service is operated by Anglican Care Waiapu Ltd and managed by a facility manager and a clinical manager. All residents and family members interviewed spoke positively about the staff, personalised care and the standard of services received.

This provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the Tairāwhiti 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.

Two areas requiring improvement were identified at this audit relating to staff undertaking tasks outside of their scope of practice without appropriate training and an environmental issue.

Consumer rights

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff have received ongoing education on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

The many residents at the facility who identify as Māori and their whānau report services were meeting their cultural needs. Services are planned to respect the individual culture, values and beliefs of all residents.

Residents, whānau/family members and external health providers interviewed, stated that communication is excellent at this service. There was evidence that residents, whānau/families and other parties are provided with full and frank information in accordance with the principles of open disclosure. Appropriate written consents have been obtained.

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

Organisational management

The organisation's vision, purpose, mission statement, core values and passion is displayed in the reception and is used to develop a facility specific business and continuity plan. The quality programme includes compliments, complaints management, incident reporting and policy and procedure review. Service provision is closely monitored and regular meetings and monthly reporting by the facility manager is completed and sent to the governing body. Policies are current and available to staff. There is also a documented quality and risk management plan. Hazards and risks are being identified, managed and reviewed. Internal audits and surveys are conducted. Where improvements are required this occurs in a planned manner. Essential notifications are lodged as and when needed. Regular resident and staff meetings occur.

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

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 ongoing education.

The staffing and skill mix requirements are implemented to ensure the resident's care needs are met. The requirements align with the provider's contract with the Tairāwhiti District Health Board.

The quality and compliance manager for Heritage Lifecare Limited (HLL) provided evidence of transitional plans which do not include changes to the present management structure.

Records reviewed are complete and current and include identifiable signatures and staff identification. All current and archived records are secured.

Continuum of service delivery

Entry criteria for the facility is documented and available for any person and referral agency. The facility manager or clinical manager discuss any prospective referral with the referral agency to ensure admission is appropriate. If entry to the service is declined, a record is maintained.

Residents receive timely and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified/experienced staff competent to perform the function.

The processes for assessment, planning, provision, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The interRAI assessment tool has been partially implemented with a plan in place to complete these. Care plans reviewed described the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions is consistent with, and contributes to, meeting the residents' needs and improving outcomes.

Evaluation of care is consistently documented at least six monthly.

Support for access, or referral, to other health and/or disability service providers is appropriately facilitated.

The service provides an activities programme which reflects residents' preferences. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

A medication management system is in place that meets all legislative and guideline requirements. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The menu has been reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported satisfaction with the meals and choices provided.

Safe and appropriate environment

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 warrant of fitness. Clinical equipment has a current calibration. Electrical safety checks of appliances are up-to-date. The security arrangements and practices promote a safe environment. A preventative maintenance plan is well implemented.

There are five double rooms but all are used for single occupancy. Showers and toilets are adequately situated in close proximity to the residents' rooms. Personal spaces are sufficient for residents, including those who require staff assistance or the use of mobility devices. There are separate lounges and dining areas. There is good indoor/outdoor flow with a separate covered shade house and sail shade provided over the deck areas for the residents and families to use. The facility has adequate heating and ventilation.

Cleaning and laundry services are provided by employed staff. These services are monitored through the internal audit programme and resident satisfaction process. Residents and families confirmed the facility is kept clean and comfortable.

Emergency policies and procedures documented in the emergency plan provide guidance for staff for all possible emergency events. There is an approved evacuation plan and fire evacuation and emergency training is conducted six monthly. There are sufficient supplies available on site for use in the event of an emergency or an infection outbreak.

Restraint minimisation and safe practice

The service has a commitment to restraint minimisation and safe practice. Safe policies and procedures are implemented. Eleven restraints are in use and two enablers at the time of this audit. Enablers are used as a voluntary measure and aid independence. Written consents were on each resident`s records reviewed. A comprehensive assessment, approval and monitoring process is implemented. Regular reviews occur. Restraint is only used as a last resort when all other options have been explored. The restraint coordinator maintains the restraint register.

Staff interviewed are fully informed and are aware of the difference between restraint and enabler use. Staff have access to training on managing challenging behaviour and safe and effective alternatives to restraint at orientation and annually.

Infection prevention and control

The registered nurse responsible for infection prevention and control has a defined role to manage the environment and minimise the risk of infection to residents, staff and visitors. The service has a clearly defined and documented infection control programme that is reviewed at least annually.

Staff files, observation and interviews verify initial and ongoing infection control education occurs.

Surveillance for infection is conducted monthly and annually and transferred to an annual data sheet. There is evidence of a continued reduction in infections and a proactive approach to continue this trend.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	2	0	0	0
Criteria	0	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>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) was displayed throughout the facility. Residents and family reported that they were provided with copies of the Code as part of the admission process.</p> <p>Staff demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.</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>Files reviewed included appropriate written consents by the resident. Staff during interview demonstrated good knowledge of consent processes. Whānau/families and residents interviewed verified appropriate consents occur as part of everyday practice, and this was observed during the audit.</p> <p>There was evidence in files of Enduring Power of Attorney (EPOA) input for those who could not consent themselves.</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>	<p>FA</p>	<p>Residents and whānau/families interviewed reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service was included in the admission package, with the brochure available at the entrance to the service. Education was conducted as part of the in-service education programme for staff. Staff during interview demonstrated knowledge of advocacy processes.</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>	<p>FA</p>	<p>Whānau/family reported that they are encouraged to visit at any time, and are always welcomed. Residents are supported and encouraged to access community services with visitors, or as part of the planned activities programme. There is evidence in residents' files that this occurs regularly. Staff were observed welcoming visitors and encouraging outings.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints and concerns policy which meets the requirements of the Code. There is a flowchart associated with the policy to assist staff in understanding the process of complaints management. The manager stated information is provided to family members on admission. Complaints information is available at reception and the nurses' station. This was confirmed by staff during interview. Family members spoken with know the complaints process and who they would approach if they had a concern; this included the manager, clinical manager or the registered nurse on duty.</p> <p>The complaints register reviewed showed that all complaints are recorded on an organisation complaints template and that all complaints lodged had been dealt with appropriately from the date the complaint was lodged, complainant details, nature of the complaint, actions taken through to resolution.</p> <p>The manager is responsible for complaints management and follow-up. Any significant complaints, that for example involved a staff resignation or the DHB, would be signed off by the operations manager. All</p>

		<p>complaints are reported to the Anglican Care Head Office monthly to be collated, analysed and any trends identified.</p> <p>Training on the complaints policy, processes and open disclosure was provided annually. Staff interviewed confirmed they received related training and demonstrated a sound understanding of the complaint process and what actions are required. Training was confirmed on review of the 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>Whānau/family and residents interviewed reported that the Code was explained to them on admission, was included as part of the admission pack, and time was allowed for them to understand the information.</p> <p>The prospective provider during interview demonstrated knowledge and understanding of the Code and their need to adhere to these.</p> <p>Nationwide Health and Disability Advocacy service information is also included in the admission pack with brochures available at the entrance and hallways of the facility. Residents and whānau/family interviewed reported that they were aware of their right to access advocacy services but they had not needed to do so.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and whānau/family interviewed reported that the residents are treated in a manner that shows regard for the resident's dignity, privacy and independence. Files reviewed indicate that residents received services that are responsive to their needs, values and beliefs.</p> <p>Residents, whānau/family, and one general practitioner (GP) interviewed did not express any concerns regarding abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were 41 percent of residents who identified as Māori at the time of audit. There were also a high percentage of Māori staff. The clinical manager (CM) reported that there are no barriers to Māori accessing the service. Staff interviewed demonstrated a good understanding of services that are commensurate with the needs of Māori.</p>

		Māori residents and whānau during interview reported their cultural needs, values and beliefs were met and this was done particularly well at Te Wiremu House.
<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	Residents' files reviewed demonstrated consultation with the resident and family/whānau on the resident's individual values and beliefs. Whānau/families reported they were consulted with the assessment and care plan development. Staff interviewed demonstrated good knowledge on respecting each resident's culture, values and beliefs
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Staff employment documents had clear guidelines regarding professional boundaries. Whānau/families and residents interviewed reported they were very happy with the care provided. Whānau/families and residents expressed no concerns regarding breaches in professional boundaries and all reported a very high satisfaction with the caring, calming and professional manner of the staff.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	PA Low	<p>There are several examples of good practice implemented at Te Wiremu House. Evidence-based practice was observed, promoting and encouraging good practice, including consultation with specialists for any issue.</p> <p>Registered nurses (RNs) are supported in ongoing professional development. Three registered nurses (RN) are trained in interRAI assessments, with the other RN's on a waiting list for training. All RN's are trained in the use of syringe drivers and first aid. The organisation has supported staff attending 'Hospice NZ' palliative care training which commenced in February 2016.</p> <p>Two RN's complete the Professional Development and Recognition Programmes (PDRP) Pukenga Haumanu and Pukenga Māori Motuhake every three years.</p> <p>There is regular in-service education and staff access external education that is focused on aged care and best practice and fully</p>

		<p>supported by the organisation.</p> <p>Engagement of external health professionals to support staff contributes to evidence based outcomes for residents.</p> <p>There are, however examples of staff undertaking tasks they are not trained for.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff demonstrated that they understand the principles of open disclosure. Residents, whānau/family and the GP confirmed they are kept informed of the resident's status, including details of events which may have affected the resident. Evidence of open disclosure is documented within each resident's file. All interviewees reported that communication is excellent.</p> <p>At the time of this audit there were no residents who required interpreter services to ensure effective communication. Both the CM and staff during interview demonstrated their understanding of the organisation's processes for obtaining these services should they be required.</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>	FA	<p>The vision, purpose, mission, core values, passion, direction and strategic objectives for Te Wiremu House for 2016/2017 are documented in the service business plan, displayed in the reception of the facility and provided in the service information booklet and the resident's admission pack.</p> <p>The facility manager interviewed provides regular monthly reports to the organisation's head office inclusive of occupancy, general comments on movements, complaints, health and safety and compliance issues (incidents/accidents) new risks identified and any outstanding issues. Information is then used to inform decisions made at the weekly operations meetings and the monthly board reports. Feedback from the board comes from the senior management team and operations managers to the facility manager.</p> <p>The roles and responsibilities of the manager and clinical manager are</p>

		<p>detailed. The manager has attended regular education relevant to managing an aged residential care service in the last year, as required. The facility manager also maintains currency through attending conferences and updates from the Ministry of Health 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 the DHB currently for psychogeriatric services, dementia services, medical/hospital services, rest home services and respite services. On the day of the audit seventy-seven residents receive services under these contracts, three of whom were under 65 years of age. There were twenty-nine hospital residents, thirty-two rest home residents, and sixteen dementia residents. The two respite residents included one resident receiving rest home level care and one receiving hospital level care. Full occupancy would be 94 residents. The contract for the psychogeriatric service (six beds) was the last agreement arranged with Tairāwhiti District Health Board (TDHB). This unit accepted the first resident on the 14 January 2016. The unit has been underutilised with only two residents being admitted to this unit. Currently there are no residents in this unit. A reconfiguration application has already been sent to the DHB for consideration of hospital level beds.</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 reconfiguration of the services is planned to achieve 10 rest home beds, 14 dementia and 70 dual service beds. The quality and compliance manager interviewed, provided evidence of planning for the transition and a transition plan and checklist was developed. Weekly transition meetings are held to monitor progress and responsibilities to be completed within set timeframes. No changes are planned to change the registered nurse full time equivalents. The Tairāwhiti DHB and the Ministry of Health are aware of the plan to purchase this service</p>
Standard 1.2.2: Service Management	FA	When the facility manager is absent, the clinical manager carries out all the required duties under delegated authority. The clinical manager has

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>been at this facility for over six years and worked at the DHB and an aged care service prior to this appointment. Experienced registered nurses are available to take responsibility for any clinical issues that may arise when the clinical manger is absent.</p> <p>The HLL quality and compliance manager stated 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>	<p>FA</p>	<p>The organisation has a quality and risk system that is overseen by the Anglican Care Waiapu clinical and compliance manager and delegated to the facility manager. The quality and risk plan sighted reflects the principles for continuous improvement and was understood by the staff interviewed. This includes the management of complaints, incidents/accidents, internal audit activities, a regular satisfaction survey for residents and families, monitoring of outcomes, clinical incidents including infections, falls, skin tears and pressure injuries.</p> <p>Monthly quality and risk meetings are held. Topics on the set agenda reflect and include results of audits, infection prevention and control data, use of restraints/enablers and the number and type of incidents reported, interRAI update, Careerforce/education and training, falls, wounds/skin tears/pressure injuries, facilities, quality and risk management statistics, trend analysis, movements of staff, occupancy and any correspondence and other topics. Minutes of meetings were available and reviewed. The minutes evidenced that staff are informed of all quality issues and this was confirmed by staff interviewed.</p> <p>An annual review of the quality programme also occurs. The report is detailed. The service benchmarks with other services in the organisation and results are published and fed back to staff at the facility. The service features favourably as compared to other benchmarked facilities in falls reduction, infection rates, episodes of challenging behaviours, residents requiring admission to hospital and restraint minimisation and safe practice.</p> <p>A comprehensive internal audit schedule is developed and implemented. Audits sampled confirmed good compliance by staff in meeting the requirements of the policy and audit criteria. The annual</p>

	<p>customer satisfaction survey in November 2015 received a 96% response rate. Any areas requiring improvement from the survey have been actioned. An annual staff survey has recently been distributed and is now in progress. The manager interview is responsible for completing all non-clinical audits and the operations manager and clinical manager complete the clinical audits as per the schedule. Any corrective actions are documented in red ink and are not signed off until completed.</p> <p>Policies and procedures are available to guide staff. Policy development, review and document control is undertaken by the clinical quality and compliance manager who 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 members at each facility. The manager ensures the staff are updated on new policies or changes to policies through `Time target` (staff electronic system utilised by staff), notices and at staff meetings. Staff interviewed reported they are kept updated with all relevant information required. Regional quality meetings are held for facility managers also to review policies and to contribute to submissions if required.</p> <p>The facility manager provided evidence from the organisational strategic plan of the identification and mitigation of strategic risks. These are reviewed annually. The manager and clinical manager are well informed about health and safety and have undertaken training, including the Health and Safety at Work Act (2015). The manager 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 required. The organisation 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 requirements of the standard and contract requirements. The plan is to review the current plans and work towards a combination of both processes.</p>
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<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 interviewed were well informed about adverse and near miss events and how to record them on the incident form available. The care staff ensured the registered nurses on duty were informed. The clinical manager is responsible for follow-up including investigation as required. A sample of incident forms show they are fully completed, incidents are fully investigated, action plans are developed and actions are followed-up in a timely manner. Applicable events are also disclosed to the resident and or designated next of kin. The GP interviewed stated contact was always made for any relevant adverse events. This was verified by resident and family members interviewed who confirmed they are always kept informed. There have been no Health and Disability Commissioner, coronial enquires or police investigations.</p> <p>Adverse event data is collated and analysed 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 quality and risk meetings evidences incidents/accidents are discussed in relation to trends, action plans and improvements made.</p> <p>The facility manager and clinical manager interviewed are fully informed of their obligations to report to external agencies as required. Legislative requirements are documented in policy reviewed. A recent infection prevention and control outbreak was managed professionally by staff and the medical officer of health (Public Health), HealthCERT and MoH were informed.</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 are available for all new employees relevant to their role. The position descriptions were current and defined the key tasks and accountabilities for the various roles. The recruitment process is comprehensive and 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</p>

	<p>systematically maintained. A check list was visible in all staff records for auditing purposes reviewed.</p> <p>Orientation workbooks (role specific) included all necessary components relevant to legislation, these standards, contract requirements and good practice. Staff interviewed reported that the orientation process prepared them well for their role and included support through a `buddy system` until they felt confident to perform their role. Staff records reviewed show documentation of completed orientation and performance review after a three month period of employment and ongoing annually.</p> <p>The facility manager confirmed that continuing education is planned on an annual basis. Organisation mandatory training which includes six monthly fire evacuation and emergency training, annual training on the Code of Rights, health and safety, restraint, manual handling, infection control, cultural safety, documentation, pressure injury prevention and medication management is documented by the facility manager. Additional training includes end of life care, pain management, the aging process and continence management. A record is maintained by the clinical manager of the date, education session, presenter, qualifications/experience, attendance and venue.</p> <p>Specific education is provided for the registered nurses such as end of life care planning, interRAI, palliative care and medication administered through pump syringe drivers and medi-map responsibilities. Three of 12 registered nurses inclusive of the clinical manager have been fully trained for completing the interRAI assessments. Time is allocated for the registered nurses to complete the assessments.</p> <p>All staff have evidence of Aged Care Education (ACE) training in their individual records and the training status form was sighted to evidence education for Careerforce. Minimal staff have yet to complete the ACE advanced training and have until the end of 2016 to complete these modules. All staff will be transferred onto the Careerforce training in January 2017. Any new employees will commence training 2017. The clinical manager is an internal assessor for this service.</p> <p>Staff who work in the kitchen have completed food handling courses. Cleaning and laundry staff have also completed relevant training inclusive of products used, use of material data sheets and spill kit</p>
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		management if required.
<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>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 manager is responsible for rostering of staff and covers the service Monday to Friday full time. Staff work mostly permanent shifts. Registered nurse are on all shifts. No bureau staff are utilised at this service. Staff interviewed stated that they fill in shifts when a staff member is unwell or on leave. The night duty has the minimum number of staff which is one registered nurse and four caregivers. All shifts are adequately covered on the rosters reviewed, with some shorter care staff shifts that cover the busy times in the facility for example 9am to 12md in the rest home and 7am to 1.30pm in the hospital wing.</p> <p>Family interviewed and observation during the audit confirmed staff are providing services required of them.</p> <p>The quality and compliance manager for the prospective provider is well prepared and stated that the staffing ratios will meet contractual obligations and industry standards.</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>	FA	<p>A review of clinical records and interview with the clinical manager and RN's confirmed that information is entered into each resident's integrated file in a timely manner. Records reviewed were integrated, dated signed and legible and include the designation of the staff member.</p> <p>Current resident records are not publicly visible. InterRAI assessment information is accurately entered into resident's record.</p> <p>Current residents' old notes and archived records are stored in a secure room. These were observed to be well organised and dated.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>The facility manager (FM) or clinical manager (CM) logs enquiries and documents interview responses to gauge if the prospective resident is</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>suitable for their facility. The residents are required to have an assessment for hospital, dementia or rest home level of care. The FM and CM reported that they communicate regularly with referring agencies to ensure admissions are appropriate for the facility.</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>When admission is required to the acute care hospital, the service completes a transfer form. The referral process documents any risks associated with each resident's transition, exit, discharge, or transfer. With the transfer form, the RN also provides a copy of any other relevant information, such as the medication chart. A file of the one resident reviewed with a recent admission to the acute care hospital evidenced that the transfer to and from the hospital was effectively managed.</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>All aspects of medicine management are being undertaken according to medicine management policies and procedures, legislative requirements and the Ministry of Health guidelines for the management of medicine in aged care facilities.</p> <p>Most medicines are supplied by the pharmacy in a roller pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the electronic medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists. An electronic medicine prescription system is implemented.</p> <p>Safe medicine administration was observed at the time of audit. All records were accurately completed.</p> <p>The medicines and medicine trolley are securely stored. The medicine fridge is monitored for temperature, with the sighted temperatures within medicine storage guidelines. The controlled drugs are stored in a locked safe in a secure room.</p>

		<p>All the electronic medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts recorded the regular, short course and pro re nata (PRN – as required) medicines for each resident. When medicines were discontinued, these were removed by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p> <p>Medication competencies were sighted for all staff that assist with the medicine management; this included the RNs.</p> <p>The RN interviewed reported that there was one rest home resident who self-administers inhalers, and this was sighted to be in accordance with the facility's policy and procedures.</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>A chef manages the kitchen and was interviewed during the audit. The current menu was reviewed by a dietitian as suitable for the older person living in long term care. If there are changes to the menu these are recorded and referred to the dietitian at the next review. A diary records any changes. All residents and whānau/family interviewed were very satisfied with the food and food services.</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met.</p> <p>There is food available 24 hours for those who wish to snack at night.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates.</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>	<p>FA</p>	<p>The FM and CM report that they have not declined entry to any potential residents who have an appropriate needs assessment. Both confirmed that if entry to the service was to be declined the referrer, potential resident and where appropriate their family, would be informed of the reason for this and of other options or alternative services.</p> <p>The facility's admission agreement contained information on the termination of the agreement. This documents that if a resident's needs changed and if the service can no longer provide a safe level of care to meet the needs of the resident, they would be reassessed for the appropriate level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The service has not yet implemented the interRAI assessment tool for all residents; however, a plan is in place for this to occur. The interRAI or detailed paper based assessment is used to inform and develop and review the care plan.</p> <p>Care plans sighted reflected the assessed needs of the residents. All residents' physical, psycho-social, cultural and spiritual needs are fully documented as part of the assessment process. Goals are individual and consistent with meeting the outcome needs of the residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plan files reviewed were individualised and developed from interRAI and other assessment tools, reflecting the resident's individual needs. The residents' files and care plans demonstrated a wide range of service delivery. Integrated files had one main folder that contained the medical information, nursing assessment, care plan, routine observations, activities, therapies, family correspondence and specialist consultations.</p> <p>Residents and whānau/family interviewed reported that they are consulted at the time of care plan reviews and staff delivered services in line with their wishes. The GP interviewed expressed a high level of satisfaction with the care provided.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Services are being delivered according to information in resident's individualised care plans.</p> <p>Health variance plans are being developed for short term problems, such as skin tears, wounds, decreased mobility and infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in the care plans.</p> <p>Staff informed that they report any concerns about a resident, such as a change in their condition, both in the progress records and to the RN, and this was confirmed in documentation reviewed and interview with the RN.</p> <p>Whānau/family and residents spoke very highly of the level of care and support provided and consistently stated that all of their needs are being met. The GP during interview confirmed that his interventions ordered are always implemented.</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>On admission a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. A range of activities are planned for each month and copies of the monthly activity schedules show that options are varied.</p> <p>Two diversional therapists (DT) implement the activities programme. During interview the DT's reported that options for group activities are discussed regularly with residents and whānau/family.</p> <p>Residents and whānau/family reported they are happy with the activities available. They confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record of this is retained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Evaluation of both short and long term care plans is occurring within recommended timeframes with detailed outcomes/goals included. Six monthly reviews of care plans are occurring. Both residents and family</p>

<p>comprehensive and timely manner.</p>		<p>are consulted and are informed when changes are identified. This was confirmed during interviews and via the multidisciplinary review and family communication forms.</p> <p>Information is being included in progress notes and changes are being made to interventions on care plans when indicated. Staff interviewed stated they are consulted prior to evaluations.</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>The GP arranges for any referral to specialist medical services when it is necessary. The residents' files reviewed had appropriate referrals to other health and diagnostic services. The CM and RN confirmed that they utilise external services as much as possible. Referrals were sighted for consultations with general medicine, surgery, mental health, pathology, dietitian, radiology and cardiology services. The GP interviewed reported that appropriate referrals to other health and disability services were well managed at the 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 good practice. The policy also details procedures for blood and bodily fluids management and disposal.</p> <p>Chemicals were seen stored in designated and secured areas around the facility. Material safety data sheets detailing actions to take in the event of an exposure were sighted for chemicals in use. Appropriate staff have undertaken training in chemical management.</p> <p>An external company is contracted to supply and manage the chemicals for cleaning, the kitchen and the laundry. The company provides relevant training for staff and a monthly report is provided to management. Staff interviewed knew what to do should any chemical spill/event occur and state they would report any related incidents in a timely manner via the incident reporting system.</p> <p>Personal protective equipment (PPE) was available on site including disposable gloves, hair covers, aprons, masks and face protection. A spill kit was readily available. A comprehensive emergency kit with PPE</p>

		<p>is also available 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>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 6 July 2017 and is displayed in the reception area to the facility. There is a comprehensive and proactive maintenance programme implemented. Two maintenance personal interviewed are responsible for this area of service delivery. Any maintenance issues observed by staff are documented in the communication maintenance record book reviewed. The testing and tagging of electrical equipment is undertaken annually. A private contracted company performs this role and calibration of all bio medical equipment is also undertaken by a designated company. Records were reviewed. Inventories of all equipment and resources are well maintained.</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 maintenance staff undertake regular monitoring of the hot water temperatures which shows this is being maintained at the required temperature for residents' safety.</p> <p>The external areas are safely maintained and are appropriate for this aged residential care setting. The environment is conducive to the range of activities undertaken in these areas. Safety is paramount and all efforts are taken to ensure the environment is hazard free and that residents are safe. There are deck areas with shade provided for the warmer days that residents and family can use. The grounds are well maintained and attractive for residents and visitors to the facility. Family members interviewed and the family satisfaction survey results evidence that they are happy with the environment.</p> <p>On observation of the internal areas of the facility carpets are worn and some permanent stains are evident in the rest home and near the nurses' station. The laundry was currently being renovated. Two internal walls are to be demolished, and new floor coverings and work benches installed. Building consent has now been authorised (see CAR 1.4.6.3).</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>	<p>FA</p>	<p>There is a mix of toilet and shower facilities in each wing. This includes rooms with ensuite bathrooms, and communal toilets and showers. An adequate number of accessible toilets and bathrooms are identified throughout the facility in close proximity to the resident's individual rooms. Staff and visitor toilets are available and separate from residents' toilets. Enrolled nurses and caregivers interviewed confirmed there are enough bathroom and shower facilities for the residents' use. Privacy locks are present on bathroom doors.</p> <p>Approved handrails are installed in each toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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>	<p>FA</p>	<p>There are five double rooms in the facility which are used as individual rooms only. One whānau room is located in Kauri wing. All other rooms are individual rooms and all rooms are large enough to enable residents and staff to move freely around within the bedrooms safely with the use of mobility aids. Each room is personalised with resident's own photographs, pictures and other personal items providing a homely atmosphere.</p> <p>There are areas for the safe storage of mobility aids such as hoists, walking frames and wheelchairs. Staff interviewed reported adequacy of bedrooms. 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 with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas small and large are available in each wing for residents to engage in activities. The dining and lounge areas are spacious and enable easy access to residents and staff. Furniture is appropriate to the setting and resident needs. It is arranged in a manner which enables residents to mobilise freely and to sit comfortably if relaxing and/or watching television. There are kitchenettes situated in the smaller wings where food is served and staff can assist residents with meals.</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>PA Low</p>	<p>Policies detailed how the cleaning and laundry services are to be provided. Resident`s personal clothing is washed individually at the frequency agreed with the resident and family. The residents and family members interviewed confirmed the facility is kept clean and tidy and residents` laundry is washed and returned in a timely manner. Audits of the cleaning and laundry services were undertaken regularly and reports demonstrated a high level of compliance with the policies documented and service requirements and prompt remedial action where improvements were identified.</p> <p>The customer satisfaction survey includes questions related to the environment cleanliness and laundry services.</p> <p>The chemical supplier undertakes regular checks to verify the chemical dilution (from the auto dispenser) is within the required range. Staff order chemicals as required.</p> <p>Chemicals are stored in designated secure sites. Instructions for managing emergency exposures to chemicals was readily available to staff. All chemicals containers are labelled with the manufacturer labels. PPE is available for both cleaning and the laundry services. The cleaning trolley is stored in a locked sluice room when not in use.</p> <p>The laundry is managed by designated laundry staff. The processes observed met good practice. Laundry staff interviewed were able to demonstrate that they followed procedures on washing and drying cycles, dirty/clean flow, handling of soiled linen and have been trained on chemical management.</p> <p>The laundry, whilst functional, is in a state of renovation with internal walls to be removed and flooring surfaces not yet sealed. A plan is developed and displayed on the wall in the laundry. Despite floors not being completed appliances have been already installed.</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) when the new build was authorised 30 May 2015. Fire evacuation drills are completed six monthly and the last was recorded on the 17 March 2016.</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 staff records and training records verifies all staff have a current first aid certificate. The caregivers interviewed detailed their responsibilities in the event of an emergency.</p> <p>There were sufficient supplies available of dried foods, drinking water (available from taps fitted to two water tanks), lighting blankets and other clinical supplies for use in an emergency. A gas hob and a barbecue are available for cooking to meet the needs of the residents. Gas heating is available.</p> <p>Call bells are present in the bathrooms and residents` rooms. The call bells alert staff to residents requiring assistance. The response time can be audited if an issue is identified. A mobile system is in use in the dementia service.</p> <p>The facility has a secure dementia unit and access is by key pad. Staff have access to all areas depending on their role within the organisation. External lighting is in place around the facility, and staff ensure and check the facility on the afternoon and night shifts. The caregivers interviewed advised the external doors and windows were checked and locked prior to darkness.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are windows present in all residents` bedrooms and communal areas having external windows or doors. Doors and windows were sighted open during the audit. Heating is provided as required via wall mounted gas heaters and/or heat pumps. Air conditioning is available in the sunroom, clinical manager`s office, manager`s office, nurse station, offices and the kitchen.</p> <p>The residents and family members interviewed confirmed the facility is normally warm and well ventilated.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The infection control (IC) RN is the CM and was interviewed. The job description for the infection control coordinator role is clearly defined.</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>		<p>There are clear lines of accountability for infection control matters at the service through the staff meetings. The FM and CM attends these meetings. The CM provides a report to the staff meeting on IC matters.</p> <p>The annual review of the infection control programme has been conducted within the past 12 months.</p> <p>The service has clear policies about staff, residents and visitors suffering from, or exposed to and susceptible to, infectious diseases. Staff reported that they do not come to work if they are unwell. Notices are placed at entrances to ask visitors not to visit if they are unwell, or have been exposed to others who are unwell. There was sanitising hand gel throughout the service for residents, visitors and staff.</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>	<p>FA</p>	<p>The IC CM attends ongoing education. The CM reported that the facility can access external advice from the hospital IC consultant, the GP, DHB and Ministry of Health services as required. Infection control is discussed at the staff and quality meetings and staff education occurs annually and randomly as part of the on-site audit process and each service stream handover meetings.</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>Te Wiremu House uses the organisation's detailed policies and procedures. Staff demonstrated good infection prevention and control practices reflective of policy. These have been designed to be fit for purpose and include best practice for Te Wiremu House residential care environment.</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>Infection control education is provided by the IC CM who has maintained her knowledge of current practice. The in-service education programme contained education and attendance sheets for IC education sessions. These sessions were referenced to current accepted good practice. Infection control practices are included in induction and orientation for all new staff.</p>

		<p>Informal education is provided as required to residents and their whānau/family. The RN gave examples of encouraging residents with fluids and personal hygiene for a resident with recurring urine infections. Staff were observed encouraging and assisting with residents' hand hygiene in the dementia service.</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>	FA	<p>The CM was interviewed. Monthly and annual analysis of infections are occurring and reported at monthly staff and quality meetings. Infection surveillance records show a consistent low incidence of infections over the past year. The facility is proactively implementing measures to continually reduce infections. A recent increase of eye infections was tracked to a staff member who was unaware of the risk. Training and recommendations were put in place with an immediate reduction in the infection rate.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The facility has a suite of policies and procedures for the use of restraints and enablers. The policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. These include having a restraint coordinator (there is a position description for this role). The clinical manager is the restraint coordinator. Eleven residents are using a form of restraint (7 bedrails and 4 pelvic belts) and two enablers (bedrails) are in use to aid mobility and independence.</p> <p>Staff interviewed had a good understanding that the use of enablers was a voluntary process along with approval and informed consent processes. Signed consent forms are on records for the enablers in use. The resident care plans detail the use of enablers. Monthly resident enabler reviews verifies that enablers are being used appropriately and safely.</p> <p>Staff have access to education on safe and effective alternatives to restraint at orientation. Managing challenging behaviour is included in the ongoing education programme. Restraint is used as a last resort when all alternatives have been explored.</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 manager, one enrolled nurse, two registered nurses, one team leader care staff member and the GP. The approval group is responsible for the approval of the use of all restraint processes, as defined in the restraint minimisation and safe practice policies and procedures. This was evidenced in the minutes of the restraint meetings, review of resident records and interview with the restraint coordinator, the clinical manager. There are clear lines of accountability for the approval group to follow. All restraints have to be approved, and the overall use of restraints is being monitored and analysed.</p> <p>A restraint compliance audit was performed on 11 May 2016 (six monthly). Restraint training was provided last on the 15 June 2016. Any staff who were unable to attend completed a questionnaire and this was recorded.</p> <p>A sensor chair mat is available and this is working effectively. Bedrails are checked monthly by maintenance personal. Monthly statistics for this facility quality and risk monitoring includes restraint minimisation and safe practice. The manager sends all details to head office where information is analysed, graphed and benchmarked prior to sending back to the facility manager.</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 includes all requirements of the standard. One resident record was reviewed and a family member was interviewed. Bedrails are used in this instance. Restraint minimisation and safe practice consent approval form was sighted and had been signed by the family member with enduring power of attorney (EPOA) and by the general practitioner. A plan was developed and implemented for the individual resident. Monitoring frequency was documented and completed as requested on the plan. Six monthly review with outcomes documented were reviewed and this was signed off by the registered nurse.</p> <p>A bright sticker was used to highlight potential risks on the care plan, for example the bed safety rail could contribute to a leg injury, the resident</p>

		<p>climbing over the side and entanglement. The informed consent form was sighted and the care plan was updated. The registered nurse documented in the progress notes and the care plan was reviewed six monthly. Cultural considerations, alternatives and desired outcomes to ensure the residents` safety and security was documented. Independence was encouraged for all residents using a restraint and/or enabler use.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	FA	<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`s cares are being effectively met with recording of all cares, nutritional input and safety considerations required. The monitoring form is kept in the resident`s record and used by the restraint co-ordinator for monitoring of the restraint use and to ensure the requirements of the policy are met. This was completed in the sample of residents` records reviewed where restraint/enablers were in use. On visual inspection residents were observed using bed rails and pelvic belts and it was observed that dignity and privacy was respected.</p> <p>A restraint register is maintained by the coordinator, updated monthly and reviewed at each restraint approval group meeting when each resident using a restraint is discussed. The last meeting was held 26 September 2016. Minutes of the meeting were available.</p> <p>Staff have received training on restraint minimisation and safe practice. Policies and procedures are understood by staff and the safe application of restraint is considered at all times. The staff are aware at interview of fully supporting people with challenging behaviours. Minimisation was encouraged and safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	FA	<p>The review of resident records evidenced the individual use of restraints is reviewed and evaluated three monthly by the restraint approval group, six monthly as part of the lifestyle care plan and interRAI reviews, with input from family, wherever possible and documented by the general practitioner concerned.</p> <p>The evaluation includes all requirements of the restraint minimisation</p>

		and safe practice standard, and in some cases, future options are developed to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation was completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint approval group review all restraint use on a monthly basis, which includes all the requirements of the standard. Minutes of the restraint group meetings confirmed analysis and evaluation of the types of restraint used in the facility, whether alternatives to restraint have been addressed and the effectiveness of the restraint in use. The restraint coordinator reports back at the quality meeting if any trends are identified. Annually the report provides all information required and whether the restraint use has decreased or increased from the previous year.

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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	PA Low	<p>While there are several areas of good practice being implemented at the facility, there are two examples of care staff undertaking tasks that are outside their scope of practice and for which appropriate training has not been provided.</p> <ol style="list-style-type: none"> 1. Male face shaves with disposable razors, rather than with electrical shavers. 2. Care staff cutting toenails. <p>In both situations there has been a minor injury to the skin for one resident during the process. An adverse event form was completed for both incidents and the areas have healed. The RN reported that whānau/family are reluctant to provide funds for an electric shaver or the</p>	Care staff are undertaking tasks that they have not be trained to do.	<p>All staff work within their scope of practice and have the appropriate training to complete tasks</p> <p>180 days</p>

		services of a podiatrist.		
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	PA Low	<p>The staff in the laundry are providing all services for the residents however, the laundry is currently under renovation. Internal renovations not requiring consent have been commenced. Consent has now been authorised at the time of the audit. There are concerns that there are potential infection prevention and control issues with floor surfaces not being sealed appropriately and inadequate ventilation for the new dryers installed.</p>	<p>During the audit building consent has now been obtained for the internal re-development of the laundry. Some building work had already been commenced while waiting for the consent and as a consequence some of the surfaces are unsealed such as around the washing machines, dryers and the workbenches which are only temporarily installed, therefore there are potential infection control issues.</p>	<p>Ensure the planned alterations are commenced in a timely manner to eliminate potential infection control issues developing and be completed prior to impending sale of the facility.</p> <p>60 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, 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.