

Trinity Home and Hospital Limited - Trinity Home & Hospital

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 Health Audit (NZ) 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:	Trinity Home and Hospital Limited
Premises audited:	Trinity Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 September 2016 End date: 13 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:	59

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

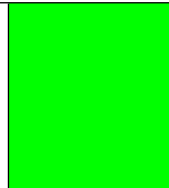
Trinity Home and Hospital (Trinity) is owned by the Trinity Trust which is a registered charity. Governance is the responsibility of the Trinity Board of Directors which consists of six members. It provides care for up to 78 residents. There are 24 secure dementia care, nine dedicated rest home level care beds and 19 dual beds which can be used for rest home or hospital and 26 dedicated hospital level care beds. The general manager (GM) is responsible for the overall day to day running of the facility.

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

There are four areas identified for improvements related to incident reporting, staff education, evaluation of resident goals and medication management.

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.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service are all accessible. This information is brought to the attention of the residents and their families. Residents and their families confirmed that their rights are being met, staff are respectful of their needs and communication is appropriate. Staff receive regular and ongoing education on resident rights and how these should be incorporated in their daily practice

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Written consents are obtained as required. Residents are treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse or neglect.

The GM is responsible for the management of complaints. There is a complaints process which identifies resident, family/whanau and visitor rights to make a complaint. All documented complaints processes are implemented.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The board undertakes governance processes and includes business and strategic planning to ensure all aspects of service delivery are reviewed and services are provided to meet residents' needs.

There are documented quality and risk processes implemented by the service to support effective and timely service delivery. Corrective action planning is implemented to manage any areas of concern or deficits.

The quality management system includes an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among staff, residents and families/whānau, as appropriate. Monthly reporting of all data is presented at board level. Resident incidents and accidents are well documented and information is used to improve services as appropriate.

Human resources management processes identify good practice and meet legislative requirements. All staff receive orientation and on-going training. Professional qualification are validated and monitored. There is a documented education plan. The service employs an appropriate number of staff with the right skill mix to ensure contractual requirements are met.

There are appropriate information systems which accurately record current and confidential information. Non-current files are filed in storage and available when required.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and implemented in a timely manner. Short term care plans are developed when acute conditions are identified and resolutions are documented. Planned activities are appropriate to the needs, age and culture of the residents who reported that the activities are enjoyable and meaningful to them.

The medicine management requires an improvement to ensure information is recorded as required.

Food services meet the food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There are documented emergency management response processes which are understood and implemented. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked to meet legislative requirements.

Documentation sighted and interviews with residents and family members identify that the facility meets residents' needs with the provision of appropriate furnishings, single bedrooms, adequate toilet, bathing, hand-washing, and dining and relaxation areas. The service has a long term maintenance plan and ongoing reactive maintenance is undertaken by contracted services.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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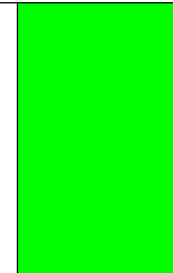
Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.

At the time of audit there are seven restraints and five enablers in use. Restraint approval and assessment processes have been undertaken to meet the requirements of this standard. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints. Restraint is used for safety reasons only.

Care planning, review and monitoring processes met all requirements.

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.

Infection prevention and control policies and procedures include a comprehensive infection control programme in order to maintain a low infection rate in the facility. The infection control nurse is currently supported by the clinical lead in the role. The type of surveillance is appropriate to the size and complexity of the service. The infection rates are discussed in the monthly staff and registered nurses meetings. Action plans are developed to reduce the infections and possible root causes are also investigated.

Infection control experts are available and consulted by the infection control nurse 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	46	0	2	2	0	0
Criteria	0	97	0	2	2	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>Staff receive education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) as part of their orientation programme. On-going education on the Code of Resident's Rights has been provided by an advocate. Staff demonstrated a good understanding of the requirements of the Code and how these are incorporated in practice. Staff were noted knocking before entering resident's rooms and closing the doors when providing cares to the residents. Residents are also addressed by their preferred name.</p> <p>New residents and their families are provided with a copy of the Code on admission and copies are displayed throughout the facility. Residents and families reported that staff respect their rights, provide privacy and maintain their dignity. The resident and family satisfaction surveys confirmed this.</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>There is an informed consent policy. Residents' records contained completed general consent forms as well as consent forms for specific treatments. Resuscitation and advance directive forms are also sighted in the resident's files sampled.</p> <p>Residents and family members interviewed reported that residents were given the opportunity to make informed choices and that consent was obtained and respected. Interviewed family members also reported that they were kept well-informed about what was happening with the resident.</p>

		Interviewed staff were able to demonstrate a good understanding of the consent process and were able to provide examples of how they obtained consent in an on-going basis.
<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	Residents and families are given with a copy of the Code and information on advocacy services during admission. Posters on advocacy services are also displayed in the facility. Interviewed residents and families are aware of the advocacy service and how to access this when needed. The community advocacy service has provided in-service education for staff and an advocate is accessible when enquired. Information on the advocacy service is part of the staff orientation programme.
<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>Interviewed family members stated that they felt welcome when they visit. When residents are able, they are encouraged to maintain their community and family links, including visits to their local church. Regular outings are arranged for the residents as well as attending other community events.</p> <p>Residents are also supported to access health care services external to the facility such as dentists. Residents and family members confirmed residents are able to continue their links with the community.</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>A complaints management policy and procedure is documented. Complaints processes reflect a fair complaints system. The complaints process is discussed with residents and family as part of the admission process. Complaints forms are available in the main foyer and/or from the nurses' station. Residents, family and staff reported that they understand the complaints process and are aware of where to find complaints forms.</p> <p>A complaints register is maintained. Complaints are a standing agenda item for staff and management meetings. All complaints are reported at board level.</p> <p>Since the previous audit there has been two complaints made to the Taranaki District Health Board (TDHB). These have been closed with one unsubstantiated and one requiring follow up. Documentation sighted shows the required follow up has been completed. At the time of audit there is one coroner's inquest open.</p>
Standard 1.1.2: Consumer Rights	FA	Documented procedures and interviews with residents, families and staff confirmed that resident's rights are understood and met in everyday provision of care. Information about the Code, advocacy

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>services and complaints process are provided on admission and displayed in both Te Reo and English. The Code is also included in the information pack provided to the residents on admission.</p> <p>Access to interpreters is available. Admission agreements are discussed with the residents and families as confirmed during interviews.</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>The service has established systems in place to ensure that residents' privacy is maintained, independence is supported/encouraged and they are treated with respect. All residents' clinical records are securely stored.</p> <p>Residents are being supported and encouraged to personalise their rooms. Staff provide privacy when providing cares to the residents. Interviewed residents and families reported that they are treated with respect, and that their individual needs are met. The resident and family satisfaction surveys confirmed this.</p> <p>The policy on abuse and neglect is well-understood by staff members interviewed. All staff undergo police vetting process as part of the employment process and records confirmed that those checks have been completed.</p> <p>Care plans reflect that residents are encouraged to have independence and resident's individual cultural, religious and social needs are documented. Residents and their families are involved in the development of the care plans.</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 are currently three residents who identify as Maori. Cultural beliefs are part of the admission process and this is reflected in the relevant section of the care plan.</p> <p>Documentation is in place to guide staff to ensure residents' needs are met in a manner that respects and acknowledges their cultural values and beliefs. The Maori Health Plan is in place and cultural awareness is provided as part of the staff education programme.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	FA	<p>Resident's personal preferences and special requirements are included in care plans. Residents and families are involved in the development of the care plans as well as ongoing reviews. Residents and families reported that they have been consulted during admission about the resident's individual cultural and spiritual values and beliefs. They also confirmed that these values and beliefs are</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		respected.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed reported that residents are free from any type of discrimination or exploitation. The staff orientation programme includes professional boundaries and expected behaviours. Ongoing education on discrimination and professional boundaries is provided to staff and this was confirmed during the interviews. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect abuse or exploitation of a resident.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Clinical policies and procedures are available to the staff to guide their practice. These reflect best practice, and are used in the everyday provision of care to the residents to ensure services are delivered to an appropriate standard. Allied health providers provide input to the care of the residents as evidenced in resident's records sampled. Regular in-service training is provided as well as on-line external education focused on best practice. The general practitioner (GP) confirmed satisfaction with the standard of care provided to residents as well as the registered nurses (RNs) clinical competencies to perform their role.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Resident records contain evidence of effective communication with residents and families. Family members are contacted when acute conditions are identified or after each GP visit. Resident and families reported that they were kept informed of any changes to the resident's health status, and were advised in a timely manner when incidents or accidents occurred. There is also evidence of resident and family input in the care plans sampled. It is reported that interpreter services can be accessed via the local district health board if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation's philosophy, mission statement and values are clearly documented, displayed at the entrance to the facility and discussed at staff meetings. Trinity has a strategic business plan in place which has been reviewed by the board. Strategic planning sets goals and objectives for the coming year and they inform the quality plan. Quality data collected throughout the year is used in forward planning where relevant. The quality plan sighted describes how the organisation's goals are monitored and evaluated by the general manager (GM) and senior staff team to ensure residents' needs are being met. Monthly reporting of

		<p>quality data is reviewed at board level and discussed at staff and RN meetings. Outcomes of corrective actions are included in reported data. The chairperson of the board meets face to face with the GM weekly to discuss any issues or concerns</p> <p>On the days of audit there were 59 beds occupied consisting of 20 rest home, 20 secure dementia care and 19 hospital level residents.</p> <p>The GM has been in the role since 2008 and maintains ongoing education appropriate to the role. The GM attends TDHB liaison meetings. The GM is supported by the acting clinical nurse manager who has worked in aged care for over four years and has been in management positions for over two years. The acting clinical nurse manager is a registered nurse who holds a current annual practising certificate. There is a clinical team leader who is also a registered nurse with a current practising certificate and is part of the senior management team. They are supported by a team of 10 registered nurses and a resource manager. All staff maintain the required education for the role they undertake.</p> <p>Interviews with residents and family members confirmed that they are happy with the services provided and that they can discuss any issues with the GM at any time owing to the open door policy. Positive management interaction with residents, family and staff was observed during the audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The service provides succession planning with the clinical nurse leader stepping up to undertake the clinical nurse manager role and the clinical nurse manager undertaking the GM duties to cover leave. The chairperson and financial advisor are available for advice as required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a quality and risk management system which was understood and implemented. This includes the development and update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared at staff meetings as confirmed in meeting minutes sighted.</p> <p>Policies and procedures are up to date and reflect current good practice. The next due date for policy review is shown and there is a process in place to manage obsolete documents. Policies and procedures are available for all staff.</p> <p>Quality data is analysed and evaluated. Trends are identified against previous data. Information is</p>

		<p>used to inform annual objectives to ensure services meet resident needs. The service has an active fall prevention programme which includes physiotherapy referrals if a resident has more than two falls in a month. This is confirmed in resident files sampled.</p> <p>Information is also gathered from the annual resident satisfaction survey and issues that arise are addressed by the management team. The 2016 resident satisfaction survey was sighted. No themes of dissatisfaction had been noted.</p> <p>Review processes for corrective actions include internal audit findings, staff meeting discussions and monthly sign off by the acting clinical nurse manager.</p> <p>The service has a risk management register which covers all aspects of service delivery. Risks are named and potential consequences, probability and control effectiveness are monitored by the board at the annual planning meeting. Actual and potential risks are identified and documented in the hazard register showing how the risks are managed and the required monitoring frequency which is decided according to the risk rating. Hazards are monitored as part of the health and safety processes. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented the hazard identification processes. Actions taken are identified in the health and safety meeting minutes.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.</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>PA Low</p>	<p>Adverse event reporting is clearly described in policy. The acting clinical nurse manager confirmed an awareness of statutory and or/regulatory reporting obligations including pressure injury reporting.</p> <p>Staff interviewed stated they report and record all resident incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Incident and accident forms for 2016 were sampled and confirmed that recorded events are well documented; however an improvement is required to ensure all incidents are captured and managed through the incident reporting process.</p> <p>Interviews and documentation sighted confirmed family are notified of any adverse events or concerns staff have about residents.</p> <p>The acting clinical nurse manager confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA</p>	<p>Policies and procedures identify human resource management that reflects good employment</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>Moderate</p>	<p>practice and meets the requirements of legislation. The staff files sampled contained completed orientation records, competencies related to the roles performed, staff education, reference checks and police checks. There is a process in place to show that staff who require annual practising certificates have them validated upon commencement of employment and yearly thereafter. Some competencies are repeated annually such as medication management and restraint minimisation. Job descriptions were sighted for all roles.</p> <p>There are individual staff education attendance records covering both on-site and off-site training and education attended. Staff are encouraged to maintain a portfolio and three RNs maintain their professional development via the TDHB. The education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relate to age care and health care services. An improvement is required to ensure that all the required training is provided.</p> <p>Seven RNs are interRAI trained and hold up to date competencies. Twenty-nine staff have a current first aid certificate. There are three staff who are aged care education assessor and caregivers are encouraged to complete recognised aged care qualifications. Staff who work in the dementia area have the required training, or are working towards it. Off-site education is also offered and staff are assisted to attend educational courses. For example catheter management.</p> <p>Resident and family members interviewed confirmed that services are delivered in a professional manner and that their needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy is implemented to ensure staff experience and skills match the requirements of services offered. Six weeks of staff rosters reviewed show that staff levels exceed contractual requirements for all shifts. There are dedicated staff rostered for the secure dementia unit. Staff stated they can complete all tasks within allocated work hours. There is evidence that staff are replaced for sick leave and annual leave.</p> <p>Residents interviewed stated all their needs have been met in a timely manner. Family members stated there are always staff available should they have any questions.</p> <p>Two diversional therapists and one recreation officer work across the facility for 116 hours per week Monday to Friday. There are dedicated kitchen, laundry and cleaning staff seven days a week.</p> <p>The GM, acting clinical nurse manager (RN), clinical leader (RN) and resource manager work 40 hours per week, Monday to Friday. The GM and two RN managers are on call and this is identified in the nurses' stations. All shifts are covered by a RN.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and to track records. This includes information gathered at the time of admission to the service, with the involvement of family. There is sufficient detail in residents' files to identify residents' ongoing care history and activities.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of residents' records. Residents' files are protected from unauthorised access by being locked in a filing cabinet in the nurses' stations.</p> <p>Entries made in resident files are legible, dated and signed by the relevant staff member or allied health professional, including designation.</p> <p>Individual resident's files demonstrated service integration, including medical care interventions and allied health. Medication records are in a separate folder with the medication.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry to services policy and procedures provide guidelines when a resident is admitted to the service. Admission agreements are signed by the residents or by their families. This was discussed in detail with the resident or with their families by the human resource manager, clinical manager or clinical lead. A welcome pack is provided to the residents and their families on admission.</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>A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or to another provider. The clinical lead reported that verbal hand overs are conducted for all transfers to other services and interRAI assessment summaries are provided to ensure continuity of care. The resident's current resuscitation status is also included together with the transfer document form.</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>PA Moderate</p>	<p>There is a documented and monitored medication management system. All medication are prescribed by the GP and reviewed as required. Medication charts have photo identification, allergies are documented and indications for both regular and "as required" medications are documented. Medication charts are reviewed every three months or more frequently when required.</p> <p>Medication reconciliation is conducted by RNs when a resident is discharged back to the service. A system is in place in returning expired or unwanted medications.</p> <p>Medication competencies are maintained. The staff administering the lunch time medications in the</p>

		<p>rest home and dementia units complied with the medicine administration policies and procedures. Current medication competencies are evidenced in the staff files.</p> <p>All medications are stored appropriately. The medicine fridge temperature is monitored and recorded daily. Weekly and six monthly controlled drugs stocktakes are conducted.</p> <p>There is one resident who self-administers medication. Policies and procedures are in place to ensure safe storage and compliance to requirements</p> <p>Improvements are required in relation to signing administered medications and writing the name of the prescriber in the controlled drug register.</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>	FA	<p>Food service policies and procedures include food safety, ordering, storage, cooking, reheating and food handling. A system is in place in receiving and utilising supplies. All meals are prepared and cooked onsite. Staff who work in the kitchen have current food handling certificates. The kitchen staff use safe food handling practices when preparing meals.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary forms are completed by the RNs on admission and the kitchen is provided a copy. Additional or modified foods are also provided by the service.</p> <p>Fridge, freezer and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the main dining area while meals in the dementia unit are transported in an insulated trolley. The meals are well-presented and residents confirmed that they are provided with alternative meals when required. All residents are weighed monthly and residents with weight changes are provided with food supplements or fortified foods.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is a policy on declining entry to service. The GM reported that they have not declined any potential resident but is knowledgeable with the process to follow when a potential resident requires a level of care need they cannot provide. The clinical lead also reported that the district health board need assessors provide the service with a completed level of care assessment to ensure the suitability of the resident prior viewing the facility.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	FA	<p>The RNs admit residents using standardised risk assessment tools. Residents are assessed using the interRAI assessment tools within the required time frames. InterRAI competent staff conduct the</p>

requirements, and preferences are gathered and recorded in a timely manner.		interRAI assessments. Trends are generated after completing interRAI assessments and these are consistently addressed in all long term care plans sampled.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long term care plans are resident-focused and personalised. The RNs develop and implement the long term care plans and there was evidence that the service promotes continuity of care. Documented goals are specific and realistic. Short term care plans are developed when acute conditions are identified. Resident, families and staff are involved when RNs developed the resident centred long term care plans. Staff are informed regarding changes in the care plans via the shift hand overs and monthly RN/staff meetings.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and caregivers follow the care plans and report progress against the care plan each shift during hand over. Monitoring forms are in use as applicable, such as weight, observations, wounds, behaviours and continence issues. Long and short term care plans are sufficiently detailed to address the desired goals/outcomes. RNs developed and implemented both long and short term care plans as identified during the assessment process.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Activities provided for the residents are appropriate to their needs, age and culture. Activities are physically and mentally stimulating. There are two diversional therapists (DTs) who develop the activity plans using the resident's profile gathered during the interview with the resident and their families. There are two diversional therapy assistants assisting the DTs. Weekly activity plans are posted where residents and families can see what is scheduled for the week. A copy of the activity programme is also provided to all residents. Activity plans are personalised and reflect the resident's preferred activities. Residents with cognitive impairment are provided with one-on-one activities. A participation log is maintained. An individual 24-hour activity plan is in place for all residents in the dementia unit. Residents are referred to the RNs when a resident's involvement in activities changes. Interviewed residents and family members reported satisfaction with the activities provided by the service.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive	PA Low	Short term care plans are evaluated in a timely manner and the resident's response to their treatment regime is documented. Goals in the long term care plans have not been consistently evaluated to indicate the degree of achievement in relation to the interventions in place. Changes are made in the interventions when the desired goals/outcomes are not satisfactory.

and timely manner.		
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There are documented policies and procedures in relation to exit, transfer and transition of residents. There was evidence that residents were referred by the GP to other specialist services. Residents and family members are kept informed of the referrals made by the service. Internal referrals are facilitated by the clinical manager and clinical lead. Interviewed staff confirmed that they refer residents to the physiotherapist when residents have changes in their mobility status.</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>	FA	<p>The service has a policy related to waste management which identifies how waste products are disposed of to ensure residents, visitor and staff are protected from harm. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes. The service actively recycles cardboard and plastics.</p> <p>Chemicals sighted are stored securely. Safety data sheets were sighted for the chemicals in use. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves as required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness.</p> <p>There is a process in place to identify and manage maintenance both long term and reactive. Electrical safety testing occurs annually by a registered electrician who provides an asset register of all equipment tested and tagged. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. The facility has ample storage space for all equipment. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents. Maintenance is undertaken as required by outside contractors.</p> <p>Outdoor areas have appropriate seating and shaded areas which are easily accessible for all residents including wheelchair access. The care facility has large grounds and an internal atrium for resident use. The secure dementia unit opens to a large secure outdoor area which residents can</p>

		<p>access as they wish.</p> <p>Interviews with residents and family members confirmed the environment is suitable to meet their needs.</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>There are adequate centrally located toilet and shower facilities in each wing and in the secure dementia unit. There are separate staff and visitor facilities. Four bedrooms have full ensuite facilities and two bedrooms have toilet ensuite facilities. All residents' bedrooms have a hand-basin. All bathroom facilities have privacy locks and curtains. There is a light outside the shower room door which lights up green when the shower is in use. Hot water temperatures are monitored and remain within safe limits.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. All bedrooms are single occupancy.</p> <p>Resident and family members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are two lounge and dining areas for the care facility and a lounge/dining area for the secure dementia unit which is divided by furniture placement. Activities are undertaken in any of the lounge areas.</p> <p>Residents and family members voiced their satisfaction with the environment.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe</p>	FA	<p>The service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and safety data sheets are readily available. The laundry is well equipped with separate clean dirty areas and entry and exit doors. Monthly checks are conducted to ensure specific</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>chemical mixes being used create clean and hygienic laundry. This was confirmed in reports sighted from the chemical provider.</p> <p>Cleaning equipment is securely stored including the cleaning trolleys when not in use.</p> <p>During interview, residents and family members confirmed they are very happy with the laundry services provided. Interviews with cleaning and laundry staff confirmed they comply with policies and procedures and they are happy with the products used.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. Staff education occurs during orientation and at least annually related to management of emergency procedures.</p> <p>The emergency plan was developed in consultation with the Taranaki District Council civil defence coordinator. There are three civil defence kits and infection outbreak boxes (one being located in the dementia unit) which are checked six monthly. Emergency supplies and equipment include food and water. The disaster contingency plan was reviewed in February 2016.</p> <p>The service has a fire service approved evacuation plan dated 06 September 2016 to incorporate changes made to the evacuation procedure over the past year. Six monthly trial evacuation drills occur and are documented. The last evacuation was undertaken in August 2016 with no follow-up required.</p> <p>Staff are required to check the doors and windows are locked at dusk. The night staff wear an emergency pendent which if activated alerts the contracted security company and the police. Exterior doors have alarms which are activated during the night. Staff and residents stated they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family members interviewed confirmed call bells were answered in an acceptable timeframe.</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</p>	<p>FA</p>	<p>The areas used by residents have at least one opening window which allows ventilation and natural light. Older parts of the facility have electric heating and the newer areas have wall mounted radiators. Residents confirmed during interview that the facility remains at a suitable temperature throughout the year.</p>

<p>is maintained at a safe and comfortable temperature.</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>	<p>FA</p>	<p>The responsibilities of the infection control nurse (ICN) are clearly defined. The ICN is responsible in collating and analysing the infection rates in each month. The service utilises the support of an infection control expert for infection prevention and control.</p> <p>The infection control programme is reviewed annually. Infection rates are discussed in the monthly staff and RN meetings.</p> <p>Residents and families are encouraged not to visit when unwell. There are hand sanitisers in the common areas and there are adequate hand basins for the residents and staff to use.</p> <p>The infection prevention and control policies and procedures are readily available in the rest home and hospital nurses' station.</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 ICN with the support of the clinical lead are responsible in facilitating infection prevention and control in the facility. They are responsible for implementing and evaluating the infection control programme. The GP reported that the clinical manager or clinical leader contact the medical centre when residents manifested acute infections. An infection control expert provides advice to the ICN. Interviewed staff have adequate knowledge in relation to outbreak management and breaking the chain of 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>There are documented policies and procedures for the prevention and control of infection in the facility. Policies sighted aligned with the current accepted good practice and relevant legislative requirements. Policies are available for the staff and procedures are simple, practical, safe and suitable for the type of service provided. Best practice is reflected in their everyday practice. Policies and procedures are reviewed annually.</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 prevention and control education is provided to staff during orientation and as a component of their ongoing education programme. The ICN and clinical lead have completed online infection prevention and control training. Residents and their families are provided with advice in relation to infection prevention and control activities i.e. hand washing. Interviewed staff demonstrated good knowledge in outbreak management and best practice in relation to infection prevention and control.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for infection rates is carried out in accordance with agreed objectives and methods in the infection control programme. Surveillance activities are appropriate to the size and setting of the service. Infection rates are monitored, data are collated and analysed by the ICN and clinical lead. Infection rates are discussed in the staff and RN meetings. Recommendations to reduce, manage and prevent the spread as well as reoccurrence of infections are discussed in these meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint.</p> <p>The service had seven restraints (two chair briefs and five bedside rails) and five bedside rail enablers in use at the time of audit. No restraint or enablers are used in the secure dementia area. Staff verbalised their understanding and knowledge related to restraint and enabler use during interview.</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>There is a nominated restraint coordinator and their job description identifies their lines of accountability for restraint. All staff interviewed were aware of the processes to be undertaken prior to restraint use. Education was undertaken in February 2016.</p> <p>Policy identifies the approval process. The only current approved restraints are bedside rails and chair briefs.</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>The assessment process meets all the requirements of this standard. It is clearly documented in residents' files sampled for restraint use. Family involvement in decision making is documented. Ongoing assessment for the continued use of restraint is undertaken by the restraint committee six monthly. The restraint coordinator undertakes a monthly review to ensure all safe use practices are maintained and that no adverse effects have been caused. Approved restraint is shown in resident's care plans and is also reviewed as part of the interRAI assessment process. The need for ongoing restraint use is discussed at staff meetings and multidisciplinary meetings.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The facility has a secured dementia unit. Doors can be electronically opened from outside by staff and visitors while a code is required to exit the dementia unit. The rest home and hospital units are not affected by the presence of the door securing the dementia unit. Restraint is only put in place for safety reasons. Alternative interventions are considered prior to restraint approval. Only approved restraints can be used as stated in policy. When restraint is in use it is monitored at a frequency decided by assessment related to identified risk to the resident.</p> <p>The restraint register sighted contains information which allows all episodes of restraint to be readily audited. The register shows that restraint is discontinued when it is no longer appropriate.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is evaluated at least every six months along with all other care provision as part of interRAI assessment process. In the files sampled restraint was identified under falls risk, mobility and restrictive devices. Annual multidisciplinary meetings which include family members and the resident identify that an updated annual consent for the use of restraint is signed. If a resident's condition changes and they can be safely managed without restraint, then the restraint is ceased. This is shown in the restraint register and in the resident's clinical file and confirmed during interview with the restraint coordinator.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>A monthly quality review of all restraint use is undertaken by the restraint coordinator. The findings are shared at staff meetings. The services progress toward reducing restraint is tracked. The restraint register identifies that over 2016 the number of restraints has remained stable.</p> <p>The restraint committee conduct a six monthly review of all aspects of restraint practice to determine the appropriateness of techniques ensure compliance with policies and procedures, safety and the use of alternative interventions. They also review the policy and procedures to ensure they reflect current good practice. Minutes from the latest review were sighted for June 2016. Part of the review</p>

		process includes ensuring the staff education reflects current good practice and meet legislative requirements. Family members are informed of the review outcome. A full audit is undertaken annually and in May 2016 the audit gained 100% compliance.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Not all service shortfalls, such as medication administration discrepancies are recorded on incident forms. For example staff non-signing for medications during administration has not been captured in the incident reporting system. When this was pointed out to management on the first day of audit a corrective action process was completed to ensure this will be addressed.</p>	<p>Not all incidents related to medication administration had been managed through the incident reporting process.</p>	<p>Provide evidence that all service shortfalls are documented on incident forms so information is accurately captured.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>The service has an annual education plan in place. This covers topic relevant to the services offered in aged care. During interview staff confirmed that they are offered monthly in-service education and that guest speakers present some of the topics, such as a health and disability advocate. Records of in-service training did not consistently identify the content of the education presented.</p> <p>Sixteen staff hold completed dementia care specific</p>	<p>Not all training requirements have been maintained. A record of the content of in-service training has not been consistently</p>	<p>Provide evidence that the annual education plan includes all the required training and that a record of the content of in-service training is maintained.</p>

		<p>education and 12 staff are working towards this.</p> <p>Training on the management of challenging behaviour has not been conducted as frequently as required. It was last conducted in 2013.</p> <p>There are eight staff who work in the kitchen and two have expired food safety certificates and six staff have not undertaken any food safety training. Food safety training has not been offered since the previous audit. One recently employed kitchen staff member stated they had never undertaken a food safety course.</p>	maintained.	90 days
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>Thirteen out of 18 medication administration signing sheets were not consistently signed by the staff to show that medications have been given.</p> <p>Staff are not consistently writing the name of the prescriber in the controlled drugs register.</p>	<p>Medicine management information has not been consistently recorded to the required level of detail.</p>	<p>Provide evidence that medicine management is recorded to a level of detail to comply with legislation and guidelines.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Two out of nine resident files sampled did not evidence that goals are evaluated and indicate the degree of achievements in response to interventions undertaken. One was last evaluated on November 2015 and the other one was last evaluated on February 2016.</p>	<p>Care plan evaluations have not been consistently completed as required.</p>	<p>Provide evidence that resident's goals are evaluated for effectiveness of interventions undertaken.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.