

Aranui Home & Hospital Limited - Aranui Home and 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 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:	Aranui Home and Hospital Limited
Premises audited:	Aranui Home and 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: 8 November 2016 End date: 9 November 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:	81

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

Aranui Home and Hospital provides rest home, hospital and dementia care for up to 89 residents in Mount Albert, a suburb of Auckland city. An audit was undertaken for certification of these services against NZS8134:2008 Health and Disability Services Standard.

Strengths of the service were the level at which all staff were actively involved in occupying residents throughout the day, the consistency and accuracy of residents' records and the management team's commitment to addressing any identified shortcomings.

Two corrective actions were identified during the audit. One related to the deterioration of the walls and fixtures in some bathroom and sluice room areas, the poor state of some bathroom and hoist equipment, and unsafe hot water temperatures; while the other related to the unsafe storage of cleaning chemicals.

Continuous improvement was evident in the organisation's proactivity in initiating, planning and instituting quality improvement projects to address changes needed. A project around staff training is also demonstrating continuous improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed high satisfaction with the caring manner and respect that staff show towards each resident.

There are no known barriers to Maori or residents who identify with the many different cultures accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' family/whanau, enduring power of attorney (EPOA) or appointed guardians. Access to information about the Code of Rights and how to make a complaint is located in reception and throughout the facility.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A mission statement and values of the organisation are documented and available to the wider public. Two managing directors (the board) privately own the facility and a general manager oversees the day to day operations. Business, strategic and quality and risk management plans provide direction and the general manager reports to the board on a regular basis.

The quality and risk system is well entrenched into the organisation with monthly meetings that include health and safety considerations plus other key components such as the incidence of infections, restraint use, internal audits, incident reports, staff training, risks and hazards. Reviews have been undertaken, data is collated and analysed and corrective actions or quality improvement initiatives developed and implemented when shortcomings have been identified. Updated organisational policies and procedures guide practices and actual and potential risks are being reviewed against the risk management plan.

Qualified health professionals have their scope of practice and current registration checked annually and accepted recruitment and employment processes, including annual performance appraisals, ensure suitable staff are available. New staff undertake a documented staged orientation and induction. Staff have access to a comprehensive selection of both internal and external training opportunities and are assessed in relevant competencies, as per their level of practice.

Rosters demonstrate that the documented recommendations for safe staffing levels are being upheld with the level of supervision and the number of staff allocated for each shift are consistent with the pre-determined safe staffing levels.

Continuum of service delivery

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

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have interRAI assessments completed and individualised care plans related to this programme.

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

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A waste management programme that is consistent with documented procedures was in place. Personal protective equipment was available for staff use.

The facility has a current building warrant of fitness. A maintenance programme was being implemented and renovations were under way to older areas of the building. Medical equipment has been calibrated and electrical checks of relevant equipment undertaken.

Personal rooms are of adequate size to enable residents to use various types of mobility equipment easily and there is sufficient room for staff to use hoists in rooms when required. Adequate numbers of toilets and bathrooms are available and although there are rooms with ensuite toilets or toilets and showers, most are communal. There are various types of communal lounge areas where residents can relax and dining areas are in different parts of the facility.

An approved fire evacuation plan is available and there was evidence that a comprehensive security checklist was being completed daily. Three different call systems operate throughout the facility and all rooms and communal areas have access to one of these. Suitable supplies for emergency situations are safely stored and are being checked six monthly.

All rooms have windows that provide natural daylight and can be opened to a safe distance. Several different types of heating installed throughout the facility are operational.

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 and procedure documentation on restraint minimisation and safe practice covers the requirements of the standard. A restraint coordinator oversees the management of restraint alongside the health and safety and quality improvement committees. Requirements for the assessment, implementation, documentation and review of the use of restraint were being upheld. Use of enablers and restraint is reported through the quality and risk management system.

Infection prevention and control

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

Standards applicable to this service fully attained.

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff and when appropriate the residents.

There is a monthly and three monthly surveillance programme, where infection information is collated, analysed and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported and discussed at infection control, health and safety, staff and resident meetings and benchmarked internally and externally.

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	1	1	0	0
Criteria	2	97	0	1	1	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 consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and this is included in the information pack.</p> <p>On commencement of employment, all staff receive induction orientation training regarding residents’ rights and their implementation. Education regarding consumer rights is held as part of the education calendar. The clinical staff interviewed demonstrated knowledge of the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents and/or family and enduring power of attorney (EPOA). Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in</p>

<p>they need to make informed choices and give informed consent.</p>		<p>their relative's care and decision making.</p> <p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff were able to demonstrate good knowledge around challenging behaviours as evidenced in progress notes, care planning and observed at the time of audit.</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>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff.</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>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in residents' progress notes and care planning, such as visiting the local shopping centre or community groups regularly visiting the facility.</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>A policy, procedure and a flow chart around complaints management detail the required timeframes. Staff confirmed during interview that they are familiar with these documents and described the process. Complaints forms were sighted at the front entrance, as was a box for complaints and compliments. Family members interviewed were aware of the complaint process and stated they feel they can raise concerns with staff or managers and are confident they will be resolved.</p> <p>The general manager is responsible for dealing with all complaints, concerns, issues and compliments at the facility. There is a register for compliments, which are acknowledged by the general manager at her discretion, in addition to a register for concerns and one for complaints. Documentation related to management of, and responses to, the registered complaints was available and meeting minutes demonstrated that all investigations are discussed at the quality, health and safety and staff meetings. Response timeframes for complaints have been upheld.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admissions agreement and states that resident rights are recognised and supported at Aranui Home and Hospital.</p> <p>The family/whanau and residents interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed that they were happy with the care at the facility provided by the staff.</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 16 residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that the staff are meeting the needs of their relatives. The resident's individual values and beliefs are recorded on admission and taken into account when developing care plans.</p> <p>The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit with observed interactions.</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>The general manager, registered nurse and caregivers interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there was one Maori resident who affiliated with their culture. The caregivers interviewed demonstrated good understanding of tikanga recommended best practices that identified the needs of the Maori resident and importance of whanau and their Maori culture and a Maori health plan was available. Initial and ongoing cultural awareness training is provided to all staff.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural policy states that the admission process includes assessing specific cultural, religious and spiritual beliefs. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture and where English is the resident's second language and enjoy the activities that are organised within the facility and within the community.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries ensuring that residents are treated with dignity and respect.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the registered nurses and caregivers and through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GP, physiotherapist, dietician and podiatrist. The facility has links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit several residents had identified English as their second language. Where hospital/consultant appointments were planned, the facility requested formal interpreters if required.</p> <p>The use of ISBAR communication tool is used by staff to ensure the accuracy of information provided to and from health professionals in relation to residents' requirements.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Aranui Home and Hospital has a facility mission statement that focuses on the aged treading safely with an easy path in the haven of love, peace and respect. Its intentions are to provide a friendly, homely atmosphere, maintain strong links with the local community, provide a mentally stimulating environment and provide a comprehensive activity programme.</p> <p>Aranui Ltd is a privately owned company. The general manager is responsible to the board of directors, which comprises the two owners of the facility. In addition to weekly emails, the general manager reports to one of the managing directors (owners) face to face most Fridays. One of the directors is also available via telephone at any time for advice on managing unexpected problems. A business plan includes a marketing plan, current and future business goals over the next two years, financial management and strategic planning. This is reviewed annually and the version sighted has been reviewed within the past 12 months.</p> <p>The general manager is suitably qualified and experienced in that she is a registered nurse with a current practising certificate, who was previously the clinical coordinator leading a large team at another facility. She has post graduate nursing qualifications and previously lectured in nursing at a tertiary institution. Since commencing the management role over four years ago, the general manager has completed management updates through various organisations, including the local district health board.</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>	<p>FA</p>	<p>During the temporary absence of the general manager, the clinical coordinator takes on the role of facility manager. According to the general manager, the clinical coordinator is also suitably qualified and experienced after having worked as a registered nurse for 20 to 30 years, four and a half of which have been in her current role at Aranui. In addition to her clinical expertise she has undertaken ongoing training, including for all internal competencies and mandatory training updates. Due to mentoring processes, she has developed management skills and assisted with implementation of the quality and risk management system. During interview, staff openly reported her proficiency and information provided was validated in her personal file.</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</p>	<p>FA</p>	<p>A quality action plan is reviewed and updated six monthly by management. This incorporates the health and safety annual objectives, which are also reviewed annually. The facility's quality policy states that they will ensure excellent life style options and care ensure resident centred care and family involvement at all stages of illness and wellness. It notes that quality activities will enhance the quality of care to the residents and a safe culture and environment will be provided for staff and contractors. Specific responsibilities of both the general manager and the clinical co coordinator for the monitoring, review and</p>

<p>reflects continuous quality improvement principles.</p>		<p>implementation of continuous quality improvement are detailed in the quality action plan. A component of the general manager's report to the manager director is a monitoring report on progress related to quality improvement topics.</p> <p>Organisational policies and procedures underpin the Aranui Home and Hospital quality management system. The document review in stage one audit showed that all were current and are consistent with the document control procedure. A separate health and safety manual is comprehensive. Monthly quality and risk meetings contribute to the monitoring of the quality and risk management plans and are minuted. Representatives from throughout the organisation who attend the meetings include caregivers, kitchen and laundry staff, the health and safety officer and the infection control coordinator for example. A health and safety meeting with the same representatives in attendance, follows the quality meeting. Issues arising from the quality and risk, and health and safety meetings are raised at the monthly staff meetings, held on the alternate fortnight.</p> <p>Monitoring systems of the quality and risk and health and safety related systems is occurring. These vary from the restraint register and restraint use reports, infection control surveillance reports following the analysis of infection data, surveys (residents February 2016 and staff March 2016), internal audits, ongoing reviews of risk management and hazard registers and the analysis of incident reporting data and human resource data. The internal audit schedule was sighted and shows 26 different issues are reviewed six monthly or annually.</p> <p>Meeting minutes demonstrated that key components of quality and risk systems are being reviewed and discussed. Examples included feedback from residents/family/ whanau and staff, complaints, restraint use, internal audits, corrective actions, health and safety, the risk management plan and reports on incidents and adverse events. The annual risk management plan up to November 2016 includes actual and potential risks under the categories of environmental, funding, organisational, severe and strategic. A separate hazard register is being maintained and discussed under health and safety, as are issues relating to the Accident Compensation Corporation accreditation that is valid until August 2017. A summary report on risk management is developed annually, as is a breakdown of the analysis of incidents and an overview of quality improvement initiatives.</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</p>	<p>FA</p>	<p>The general manager and the clinical coordinator were both aware of requirements in relation to essential notification and in addition to possible events for such notification also provided real examples such as an outbreak management and a significant injury to a resident. Both managers could quote who to report what type of event to.</p> <p>The incident and adverse event reporting system is integrated into the wider quality and risk management system. Data is collected, analysed, graphed and discussed at quality and risk management meetings. Corrective actions or quality improvement initiatives are implemented when identified to address any</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>pattern or trend. The skin breakdown and pressure injury initiatives were a result of adverse event data, as is a proposed initiative around falls prevention.</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>Professional qualifications are checked when Aranui Home and Hospital employ a health professional or commence a contract with them. Annual checks are made to ensure currency of the ongoing registration and copies of validation of these were sighted for the GP, physiotherapists, podiatrist, dietitian and enrolled and registered nurses. The general manager informed the GP accepts responsibility for his locums and evidence of this was sighted. There was also evidence that the certificates of key tradesmen used by the service provider have been recorded.</p> <p>A review of ten staff files and information from the general manager and the clinical coordinator provided evidence that demonstrates the service provider is ensuring appropriate service providers meet the needs of the residents. For example, copies of curriculum vitae, applications, interview records, notes from reference checks, annual performance appraisals and evidence police checks have been undertaken were available and sighted in the staff file review.</p> <p>New staff undertake a comprehensive orientation and induction programme with the initial part of this completed before the person commences duties, or within the first seven to ten days. All such records sighted during the staff file review had been signed off. The initial orientation covers pertinent topics of health and safety, risk and emergency management, first aid and security to mention a few. This is followed by a buddy checklist that is completed within two to four weeks, or however long the new staff person requires. An additional requirement is for a registered nurse to sign off care staff competencies within 16 weeks of commencement to confirm their level of competency to work with residents.</p> <p>The staff training is comprehensive. Over time it has gone through multiple stages of development and is now operating at a level of continuous improvement. A training and compliance plan guides the staff training programme and includes details of who requires first aid certificates, what level of training staff require if they work in dementia services, the role of Careerforce in educating staff and how staff will be able access both internal and external training opportunities. The quality assurance education manager informed that staff training was identified as an area that required improvement and a quality improvement project was instituted. This has resulted in 100% of staff having completed all training requirements for the last two years and evaluations describe benefits for both residents and staff morale.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	<p>FA</p>	<p>A staff numbers and skill mix policy and procedure was reviewed. This describes potential impacts on staffing levels and considerations to be made when rostering. Factors such as the needs of the rest home versus the dementia or hospital services have been identified and were discussed by the general manager. There is a staff roster and safe staffing guidelines document that is used by the general manager when</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>developing rosters. This has an accompanying table to aid with the calculation of safe staffing numbers. The general manager informed that the meeting of minimum standards, such as it is mandatory for all staff working in the dementia service to have or be working towards a recognised relevant qualification.</p> <p>Rosters from three weeks prior to the audit and three weeks post were reviewed. There was no evidence of gaps in the roster, or of shifts being worked short. Rosters going forward were filled with contingency names available should a person become unavailable. In addition to the general manager and the clinical coordinator being registered nurses, three others are rostered on each morning shift, one in each of the three service areas. A registered nurse works a full shift in each of the areas in the afternoon and one based in the hospital area works night shift. Numbers of healthcare assistants are consistent on seven days of the week for all shifts in each area. During a staff interview, all said they believed the general manager has a good understanding of the need to maintain consistent staffing on the rosters, to change numbers depending on acuity and confirmed they do not have to work short staffed if a person(s) pulls out from a shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit.</p> <p>All residents' files are regularly audited, remain traceable and held for 10 years.</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>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed had signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet and the facility has a dedicated website. Staff outside of normal working hours are able to show potential perspective residents and/or their family members through the facility, an information form is completed to support the facility manager in following up enquiries.</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>The service uses the ISBAR (Situation, Background, Assessment and Recommendation tool) when communicating with all external services/support. They follow the DHB's processes and forms for admission and discharge to and from the acute care hospital which include a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Transfer of a resident to another facility includes notification to appropriate and required external services. Communication between the two services and with the family occurs prior to transfer and any concerns are documented. Documentation of an acute and planned transfer was sighted during the audit and was well completed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, a process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit no residents were self-administering.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley in the treatment room which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted and meets requirements. Monthly pharmacy reconciliation of the controlled medications register was also evidenced. Medications that requires refrigeration are stored in a separate fridge.</p> <p>The 32 medicine charts reviewed have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. The medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurse and caregiver administering medicines at the time of audit demonstrated competency related to medicine management.</p>
<p>Standard 1.3.13: Nutrition,</p>	<p>FA</p>	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement,</p>

<p>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>production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed have a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a four week rotating menu. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal, with residents having the option of trays in their rooms.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The clinical nurse co-ordinator interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (DSL) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and DSL service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The facility has implemented the electronic interRAI assessment and tools for all residents. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and include falls, skin integrity, challenging behaviour, nutritional needs, continence, communication, end of life, restraint and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments identified in interRAI.</p> <p>The family/whanau interviewed reported their resident receives 'above and beyond the care required' to</p>

		meet their relative's needs.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The 16 residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual residents they care for.</p> <p>Residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files reviewed showed input from registered and enrolled nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the residents' continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book and progress notes.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>	FA	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family/significant others. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents' assessed needs and desired goals. The registered nurse and caregivers reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p>	FA	<p>The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The diversional therapist adapts activities</p>

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>to meet the needs and choices of the resident.</p> <p>The facility has three diversional therapists who individually cover the three services Monday to Friday 8am – 4pm and the hospital is supported by another 4.5 hours on a Sunday. The weekly activities plan/calendar sighted is developed based on the residents’ needs and interests and can be easily adapted and changed depending on the residents’ interest and reaction at the time. The diversional therapists advertises the upcoming activities on the calendar by providing residents on the notice boards daily through the facility and a monthly calendar of upcoming events is available. The diversional therapists are part of morning staff handover and care staff while supporting residents with personal cares remind and encourage residents to attend the activities. Regular activities include church services, regular visiting entertainment and includes trips to other events occurring in the community. Daily activities occur within the activities/dining room and the dementia unit. For residents that wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed state that they have access to activities to support residents after hours and on the weekends.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>The residents’ files reviewed have activities and social assessments that identify the residents’ individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and are assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident’s file six monthly.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents’ files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents’ changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans were sighted for wound care, infections and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents’ progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are discussed at handover: this was also evidenced at time of the audit.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident’s condition.</p>

<p>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 is one GP who visits the residents at the facility twice weekly. The facility is also supported by a GP on call after hours service. The RN or the GP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that referrals to requested services are well managed from the facility and no concerns are noted.</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>A waste management policy that covers domestic waste, recyclables, and the disposal of sharps and food waste was viewed, as was one on chemical and hazardous substance handling and storage. Education that includes correct procedures and handling is provided by the chemical product supply company. Hazardous substances are noted on the hazard register and chemical handling sheets are on display in cleaners' rooms. Attention to the safe storage of cleaning chemicals is needed, as identified in section 1.4.6 of this report. General waste, including food waste, is placed in bins and removed from the facility daily. On day one of audit these were overflowing, which was reportedly the result of a general clean up. This was not evident on day two. Recyclables are uplifted weekly and arrangements for the disposal of sharps containers are made as needed.</p> <p>Protective equipment of plastic aprons, gloves, goggles, boots and face shields is available in bathroom and sluice room areas for staff use. Staff were aware of the need to use it and evidence of staff education on its use was sighted.</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>	PA Low	<p>The building has a current building warrant of fitness, issued 3 June 2016. Relevant safety and calibration checks have been undertaken for equipment currently in use. Serial numbers of electrical equipment have been recorded and records of their last electrical safety check have been documented within the last 12 months. Contractors' documentation shows that medical equipment including thermometers, glucometers and sphygmomanometers for example have been calibrated, safety checks have been completed on beds and hoists and weighing scales have been checked for accuracy. Contractor records demonstrated ongoing checks of fire safety equipment are occurring.</p> <p>Maintenance issues and breakdowns are recorded in a maintenance book. An ongoing maintenance programme is also in place. One of two people responsible for upholding this was interviewed. The owners are also progressively renovating the facility and during the audit four residents' rooms were under renovation. Renovation of bathrooms and showers that will help to address aspects of the corrective action</p>

		<p>raised in relation to environmental health and safety are reported as being next on the list.</p> <p>An external path and garden area was fenced off where wooden framed windows are progressively being replaced with metal framed double glazed windows. There are paths around the external areas of the building; however the general manager and staff confirmed during interview that residents rarely use these areas and instead use the safe and accessible internal paved courtyards and decking areas. The dementia service has a garden that people may wander in but it is reportedly not well used, with people preferring indoor seating looking outwards.</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>A tour and plan of the facility showed that there are adequate toilet and bathroom facilities. Five residents' rooms have a full ensuite with a shower and 10 others have an ensuite toilet. There are otherwise eight communal toilets and five communal shower areas for residents' use throughout the facility. The hospital has a shower area suitable for using the shower trolley. Family members interviewed are satisfied with the mix of communal and ensuite toilet and showers and said there had not been any complaints from their relatives as far as they knew.</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 personal bedrooms are of a good size that enable residents with mobility equipment to move around them. There is adequate space for additional equipment to be used to assist people who require its use. Residents' rooms have personal items on display. Four bedrooms are double rooms with curtain partitions for privacy. The general manager noted that only residents of the same gender share a room and families of both residents are asked for permission, as well as the residents themselves. Residents are happy with their rooms and noted that they had been allowed to bring things from home if they wanted.</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,</p>	FA	<p>There is a range of different types and sizes of safe and appropriate communal areas for entertainment, recreation and dining. Three dining areas, including the one in the dementia wing, are in use. Seating areas have been positioned to take advantage of external views and/or sunshine. Visitors may take their relative/friend to one or other of these or may go to the person's room.</p>

activity, and dining needs.		
<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 Moderate</p>	<p>The managers of the cleaning and laundry services respectively were interviewed. Both were familiar with their responsibilities and showed the auditor where their instruction manuals and task schedules were. A visit to the laundry demonstrated a clean to dirty flow is being upheld and staff from both the laundry and cleaning services were aware of infection control practices. Internal audits of cleaning services and of laundry services are scheduled six monthly and evidence of these was sighted within the review of the quality management system. Corrective actions have been raised or recommendations made when cleaning or laundry services have not fully met requirements. The latest internal audits of these services were in October 2016. Efforts to address the shortcomings on the cleanliness of bathroom equipment that were identified during day one of this audit (refer corrective action in 1.4.2.1) were addressed in the evening. There is a need for the storage of cleaning chemicals to be more secure.</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 quality assurance educator informed that staff undertake training on managing emergencies, including fire safety, during their orientation and during the compulsory annual training days. This was sighted in the orientation package and the training plan information. Fire safety support and equipment that complements the sprinkler system include fire alarms, smoke doors, exits, extinguishers, hose reels and a fire blanket in the kitchen. An approved evacuation plan from the Fire Service dated 13 December 2010 is on display. Emergency lighting, gas barbecues, additional blankets and access to water in an on-site tank are examples of what is available in the event of loss of utilities. A full disaster emergency kit that is being checked six monthly is taped and sealed with a separate one for use in the event of an outbreak. Food supplies in the kitchen are always held at a surplus three or more days ahead.</p> <p>There are three types of call systems in this facility, all of which include a light above the door of the relevant call point. One also includes buzzer alarms, including in the nurses' station, and the most recently installed system alerts staff visually and audibly on their personal pagers.</p> <p>All windows have limited openings and staff are taught to close curtains at nightfall and lock doors after the evening meal. In addition to emergency procedure directions that include threats to security, policy and procedure documents describe management of security within the facility. A comprehensive security checklist is signed off each evening and copies of completed records were sighted. Staff informed they are taught not to take risks and to call for assistance if there are any security concerns.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>There is a project under way for the gradual replacement of windows with double glazing. All resident related areas have windows of good proportions, all of which have sections that can be opened for ventilation purposes. Fans assist with ventilation in bathroom areas. A central heating system that provides</p>

<p>adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>underfloor heating in the winter and a ceiling vented cooling system in the summer operates in a more recently constructed wing in the hospital and rest home area and in the dementia wing. Other older areas in the facility have wall mounted electric heating units with electric eco panel heaters in residents' rooms. Despite the underfloor system being turned off for summer and cooler temperatures outside, the facility was warm on the day of the audit visit.</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 service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the registered nurse. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover, short term care plans implemented and this is documented in progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover, in short term care plans and in residents' documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	<p>FA</p>	<p>The registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at the two staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The infection control coordinator has undertaken several external courses in infection control. The registered nurse and</p>

<p>physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current 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>An infection control policy sets out the expectations the facilities uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The registered nurse and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the registered nurse. Infection control in-service education sessions are held and resident education is provided, as and when appropriate.</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>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors urinary tract infections, cold/pharyngitis, skin infections, conjunctivitis, bronchitis and influenza-like illnesses. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in infection control and health and safety committee meetings, staff meetings, and where appropriate, family meetings. An external contractor benchmarks surveillance data quarterly with other facilities.</p> <p>The Public Health office was notified on 9 October 2016 regarding a gastroenteritis outbreak. Forty two</p>

		(42) residents, four staff and one visitor were affected. A plan was developed and health warning signs/communication were put in place. Cleaning, laundry and personal hygiene were emphasised. All legislation and standard requirements were met. Four residents were identified as requiring antibiotics due to frequent infections. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and regular evaluations. Two of the four residents have now deceased.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The facility has a restraint minimisation and safe practice policy, procedures and forms in relation to the use of restraints and enablers. There are definition of restraint and enablers which are consistent with these standards. There are not currently any enablers being used in this facility. During interview, staff described the differences between restraint and an enabler.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint minimisation policy and procedure details the lines of accountability for restraint use, including the roles and responsibilities of the restraint co-ordinator. It provides a guide to decision making before any restraint is considered and describes the consent process for residents/family/whanau or enduring power of attorney. There are forms for consent, application, approval group recommendations, monitoring and review. The use of emergency restraint, culturally appropriate care during the use of restraint and monitoring, evaluation and quality review processes. Education on restraint and enabler use is provided to new staff during their orientation and is a component of the ongoing annual staff education programme. All staff are required to complete the self-questionnaire around restraint at these times. An additional compulsory staff training session was provided earlier in 2016 following a restraint related incident. One person has currently been assessed for use bed rails as a restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A full assessment that covers the requirements as listed in (a) to (h) below is evident in the personal file of the person for whom bedrails are being used as a restraint to keep her safe. The file shows that attention has been paid to this person's cultural needs. Records also show that alternative strategies have proven to be unsuccessful.
Standard 2.2.3: Safe Restraint Use	FA	Considerations around the safety of the resident and of the safe use of the bedrails have been made in consultation with the family and the GP. All staff involved in this person's care are informed of the observations to be made and the documentation requirements. Bedrails are being used as a restraint,

<p>Services use restraint safely</p>		<p>rather than an enabler, as this person spends considerable time in bed during the daytime because of other assessed medical needs.</p> <p>Records of the use of restraint are being maintained on each shift and cover the requirements of the standard. These include monitoring records of the times restraint has been used, restraint release times and details of other activities such as feeding and toileting.</p> <p>A restraint register is maintained by the restraint co-ordinator and was viewed during the audit. The quality and risk team are involved in six monthly reviews of the register.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The use of restraint for the resident who has been assessed as requiring bedrails whenever she is in bed is reviewed as part of her routine six monthly reviews. This is evident in her personal records. A registered nurse also informed that staff report on its use as part of their progress monitoring reports, which was evident in the resident's personal file. Family are involved in the review processes and have confirmed the need for its ongoing use. An additional full evaluation and review that was undertaken following the reporting of misuse of a restraint earlier in the year was fully recorded.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint approval group, who are also the members of the health and safety team plus the restraint coordinator, meet twice a year in March and September. Meetings are minuted and records of these were sighted. The restraint approval group is responsible for ongoing reviews of the restraint minimisation policy and procedure and for ensuring the type of any restraint being used is suitable and effective for the person who has been assessed as requiring it. Alternative methods to prevent any additional use of restraint are managed through behaviour management plans, activities programmes and reviews of the environment. Such discussions are evident in meeting minutes and individual residents' records.</p> <p>Restraint compliance audits are completed by the restraint coordinator annually and reported through the internal audit system. Restraint use is a component of the quality and risk management plan and is discussed as an agenda item at the fortnightly quality and risk management meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	<p>There are newer and older sections of this facility that were built at different times. Inspection of bathroom and sluice room areas showed that in older areas of the facility the walls are chipped and swollen; some painted areas are chipped, worn and have ingrained dirt; handrails are rusted; commode shower chairs have rusted parts, broken plastic and grime and hairs around the wheels and hoists have torn padding and chipped paint. The deterioration of the walls, fixtures and equipment is posing potential health and safety risks for residents and staff who use these environments.</p> <p>There was evidence of accumulated dust, grime and dirt, especially in the older bathroom and sluice room areas, on the first day of audit. A working bee overnight addressed the surface dirt and these environments were cleaner on day two of the audit. Internal audits that monitor the cleaning programme for the facility are undertaken six monthly. Staff informed these audits have not previously</p>	<p>The deterioration of walls, and chipped, rusted and unclean fixtures and equipment in some bathroom and sluice room areas present potential infection and injury risks to residents and staff. Hot water temperatures are being reviewed three monthly; however, some recordings are higher than acceptable levels with readings up to 49 and 50 degrees Celsius on a regular basis.</p>	<p>The physical environment is safe and minimises the potential risk of infection and/or injury related harm to residents and staff; and the regular monitoring of cleaning includes bathroom and sluice room areas.</p> <p>180 days</p>

		<p>focused on these areas.</p> <p>Hot water temperatures are being checked in different residents' rooms and bathrooms every three months and are subsequently recorded. Readings vary from the low 40s to 50 degrees Celsius with 49 and 50 degrees featuring in some areas for most of the recordings. The level at which intervention needs to be taken was unknown; therefore there was the potential for residents to experience unsafe hot water temperatures.</p>		
<p>Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Moderate</p>	<p>Two examples of bottles of chemicals in unlocked sluice rooms were sighted. An unattended trolley used by a cleaner that had a range of cleaning fluids on it was in an unlocked storage room on two occasions, despite this room being lockable. A container of a cleaner was found without a lid in a sluice room cupboard. Although several mobile rest home residents have been identified as having early stages of dementia not all sluice rooms that contain chemicals and cleaning equipment are lockable.</p>	<p>Cleaning liquids of a chemical nature were in unlocked storage areas in rest home and hospital areas of the facility.</p>	<p>All cleaning chemicals and equipment are stored safely and hygienically to ensure the safety of all residents.</p> <p>90 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>Corrective action plans are developed at various levels depending on the level of significance of the identified shortcoming(s). For example, where simple solutions are simple they are managed as action points within the quality and risk or health and safety meeting process. Where additional follow-up is needed and ongoing monitoring is considered necessary to ensure the issue is resolved, a corrective action plan with a monitoring component is implemented and followed up until 100% compliance is maintained. Where change management or a different approach is required because other interventions have been unsuccessful then a quality improvement initiative in the form of a project is implemented. Eight such projects were considered as part of the audit with four looked at in more detail. These four were around prevention of skin breakdown that was occurring despite a good policy and trained staff; changing attitudes and practices in relation to turning residents during the night; staff education as despite multiple afternoon sessions being organised and incentives offered, attendance was poor; and the increased socialisation and mobilisation of residents, especially some who were more isolated. All projects were successful in that they have evaluations with ongoing improvements evident. For example, the prevention of skin breakdown initiative has now developed into a new project with a goal of reducing the number of grade one and two pressure injuries. The staff education one has resulted in 100% of staff undertaking all required</p>	<p>The development of quality improvement initiatives as a means to either address identified shortcomings, or to improve on the implementation of new or changing systems has become part of the culture of quality and risk management within this organisation. Four significant initiatives have been taken through identification, planning, implementation and evaluation or review</p>

		and recommended training for the last two years. A development on a corrective action regarding an internal audit on resident files has seen the implementation of a system where registered and enrolled nurses peer review each other's residents' records that has not only see a marked improvement in residents' files but a more positive culture within the team has been observed and confirmed.	stages. All such initiatives have contributed to improving staff knowledge, skills or capability that has ultimately improved resident care and support.
<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>	CI	<p>The quality and risk management committee identified that despite providing a range of topics for staff training monthly, and offering incentives to encourage staff participation, staff attendance remained low. A quality improvement project involved the identification of key training topics and competencies and two schedules were developed. Schedule A is delivered for a whole day in the first half of a year and schedule B in the second half of the year, which enables all topics and competencies to be covered over a 12-month timeframe. Staff are allocated which day they will attend and are rostered accordingly. Each training day is delivered up to five times to ensure all staff have been accounted for and all participants complete a feedback form/evaluation sheet, which not only covers the topic, but also the experience of the training now being delivered over a whole day and what other information they would find useful. Full day training sessions are now an accepted culture within the organisation and the evaluation results are indicative of the positive gains. Family members and residents have provided verbal feedback to managers about staff competence and written comments were in the 2016 satisfaction surveys. Managers reported there has been a corresponding reduction in the number of incidents, especially falls and medication errors. A financial costing review was also undertaken and although costs are reportedly slightly higher using this system the managers have concluded the benefits outweigh these additional costs and the process will be maintained.</p> <p>Staff interviewed provided positive feedback and talked about how the training had increased their confidence and competence. They talked about their involvement in upskilling new staff because of their own knowledge.</p>	<p>Following unsuccessful efforts to improve staff attendance at training sessions the organisation planned and implemented a quality improvement project to ensure staff met the mandatory requirements that were outlined in the staff training schedules. The quality improvement project has resulted in 100% of staff having completed mandatory training within their field of practice for the past two years. Improved staff training is enabling improved care and support for residents, which is coming through in resident and family surveys and in the reduction in incident reports.</p>

End of the report.