

Northbridge Lifecare Trust - Northbridge Lifecare Trust Rest 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 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: Northbridge Lifecare Trust

Premises audited: Northbridge Lifecare Trust Rest Home & Hospital

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

Dates of audit: Start date: 9 February 2017 End date: 10 February 2017

Proposed changes to current services (if any): Services have been reconfigured by the increase of secure dementia beds by 11 taking the total to 16 beds. Rest home level care beds have been reduced by 11. The overall capacity of the service has not changed and the total bed numbers remain at 96.

Total beds occupied across all premises included in the audit on the first day of the audit: 89

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
	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
	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

Northbridge Lifecare Trust Home and Hospital (Northbridge) provides 96 beds, consisting of 35 dedicated hospital level care beds, 16 secure dementia care, 10 beds that can be used for either rest home or hospital and 35 dedicated rest home level care beds. There is a village on the same site which is not included in this audit.

Northbridge operates as a charitable trust. At facility level, the director, who works full time at the facility, oversees all services and reports directly to the board of trustees. Care services are overseen by the lifecare manager who reports directly to the director.

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, procedures, residents and staff files, observations and interviews with residents, families/whānau, a general practitioner, management and staff.

The reconfiguration of services related to the increase of secure dementia care beds is also referenced in this report.

There is one area identified for improvement related to care planning documentation. Two areas have gained the higher than required rating of continuous improvement. They relate to medication management and quality improvement data analysis, evaluation and communication.

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.

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

There are no barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

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

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

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

The organisation respects and supports the right of the resident to make a complaint. The service has a complaint register which allows information to be recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

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.

The organisation's philosophy, mission and vision statements are clearly documented. The board of trustees ensures service planning covers business strategies for all aspects of service so the services offered meet residents' needs, legislative requirements and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, post admission resident and family/whānau surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whānau. Corrective action planning is well documented.

The Lifecare manager reports to the director via a documented reporting system and informally daily. The director reports monthly to the board of trustees including the reporting of all quality information. More frequent reporting occurs if any issues of a serious nature occur.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. Residents and families/whānau confirmed during interview that all their needs and wants are met. Staff in the dementia care unit have specific education.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. This includes the extended secure dementia care unit. Human resources management processes implemented identify good practice and meet legislative requirements.

Clinical records are integrated. The content is individualised, meets current accepted good practice, and is stored securely, including archived documents.

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 low risk.</p>
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Residents are usually admitted following a Needs Assessment and Service Coordination (NASC) assessment, to ensure access to the facility is appropriate. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Services are provided by suitably qualified and trained staff. The registered nurses are supported by care and allied health staff, including a podiatrist, physiotherapist, occupational therapist, pharmacists and three general medical practitioners. Shift handovers support continuity of care.

Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. After a full comprehensive assessment, the long-term care plan is developed and implemented. All residents' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis with the resident and family's input.

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

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice, and consistently implemented using an electronic system. Medicines are administered by staff who have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. The service has a five-week rotating menu which is approved by a registered dietitian. The kitchen has registered food safety programme. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire drills.

The building has a current building warrant of fitness and an approved fire evacuation plan which did not require updating for the secure dementia care unit as no smoke cells have changed. There have been no changes to the facility footprint since the previous audit.

The facilities meet residents' needs and provide furnishings and equipment that is regularly maintained and updated. Bedroom areas allow residents to move around freely with or without assistance. There is adequate toilet, bathing and hand washing facilities.

Lounge and dining areas meet residents' relaxation, activity and dining needs. The secure dementia care unit has a dedicated lounge/dining area that is spacious enough for up to 16 residents.

The facility is kept at a suitable temperature all year round. Opening doors and windows creates an air flow to keep the facility cool when required. The outdoor areas provide furnishings and shade for residents' use. The secure dementia care unit outdoor area is easily accessible with a pergola for shade.

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 the audit, the service had three restraints and nine enablers in use. They are either chair lap belts or bedside rails.

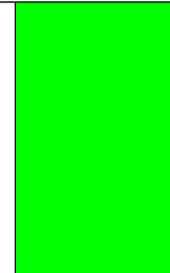
Appropriate and safe use of restraint, as set out in policy, is implemented by the service. There is a process for determining restraint approval and ongoing education and competencies for staff. Educational content includes de-escalation techniques which are understood and implemented by staff as required. Restraint is used for safety purposes only.

There is no individual restraint used in the dementia care unit.

Restraint use is fully evaluated at least six monthly and each resident with restraint is reviewed monthly at the restraint group meetings. If restraint is continued, this is discussed at the resident's family meeting and documented in the resident's notes. Approved restraint is monitored according to risk. An annual quality review of the use of restraint and policy content is undertaken.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by a senior registered nurse with the assistance of an enrolled nurse, aims to prevent and manage infections. Specialist infection prevention and control advice can be accessed from the District Health Board, community laboratory services, colleagues, and the general practitioners, as required. The programme is reviewed annually.

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

Aged care specific surveillance is undertaken, analysed, trended and results reported and fed back to staff, and discussed at the monthly continuous quality improvement (CQI) committee meetings. Follow-up action is taken when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	2	98	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Caregivers interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on residents` rights is included as part of the induction process for all new staff and is ongoing, as was verified in the training records sighted.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>A detailed informed consent policy is in place. The service ensures informed consent is part of all care plans and contact with families. Every resident has the choice to receive services, refuse services and withdraw consent for services. Informed consent is closely linked with the Residents` Code of Rights and Responsibilities.</p> <p>The service provider ensures residents/family/enduring power of attorney (EPOA) understand documents that they are signing. The service maintains records to identify whether the EPOA has been activated for individual residents or are held for future needs. These documents are held by the Lifecare manager and referenced in the resident files. The `general` informed consent form, resuscitation decision, restraint and enabler consent, consent for participating in student assessments, and influenza vaccine consent were sighted as being in use. The caregivers and</p>

		<p>registered and enrolled nurses interviewed demonstrated their ability to provide information that residents required for the residents to be actively involved in their care and decision-making. Staff interviewed acknowledge the resident's right to make choices based on information presented to them.</p> <p>Processes are implemented to review the consent related documentation on an annual basis. Residents can also document advance directives for care if they choose. Staff detailed the processes in place to ensure resident's resuscitation decision wishes were being effectively communicated.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, and information on the independent Advocacy Service. Posters detailing the Nationwide Advocacy Service were sighted throughout the facility. Staff are aware of how to access the Advocacy Service and education was provided as evidenced in the education plan and staff records reviewed. Family members interviewed also verify they are encouraged to advocate on their family member's behalf. The Lifecare manager advises that she also advocates on behalf of residents as part of her role.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending outings, activities and entertainment. This is evident in the residents' files sampled. The communication book notes details of resident outings for personal or clinical reasons. Family advised the resident is always ready at the requested time. Visitors are welcome at any time. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Northbridge implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with Right10 of the Code. During interview, residents, family/whānau and staff reported their understanding of the complaints process. Staff confirmed they report all complaints.</p> <p>The service documents the nature of the complaint, the dates received and the actions taken to address any complaint received. Documented complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the board of trustees. This was confirmed in meeting minutes sighted and during staff, director and management interviews. There are no documented complaints for 2016/2017.</p> <p>Complaints forms are on display and available to visitors and residents. The service has a suggestion</p>

		<p>box which is checked daily and complaints can be placed in this at any time.</p> <p>There were no outstanding complaints at the time of audit and all complaints have been resolved at facility level.</p> <p>Family/whanau reported that any issues raised are always dealt with at the time and they had no outstanding issues. This process is documented in residents' files.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with the registered nurse or Lifecare manager on admission. The Code is displayed throughout the facility along with information on advocacy services.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families interviewed confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Families reported there was a positive atmosphere when they visit regardless of the time of day.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (e.g., when attending to personal cares, ensuring residents information is held securely and privately). Any exchange of verbal information is managed so that others cannot hear. Privacy curtains are present between bed spaces in the four bed resident rooms. A resident and family members interviewed confirmed that staff work to ensure the privacy of residents in four bed rooms. This included on occasions asking visitors to wait outside the bedroom for a short while until resident care had been completed.</p> <p>Residents are encouraged to maintain their independence by going on outings with family in the community, community activities and attending activities of their choice. The service plan includes an area to document the resident's abilities, preferences, cultural and other individual needs as well as strategies to maximise independence. This is not always sufficiently detailed. (Refer to criterion 1.3.5.2.) Despite this, all resident's and family members interviewed confirmed services are provided that meet each resident's needs, values and beliefs.</p> <p>Staff interviewed understood the service's policy on abuse and neglect, including the signs and symptoms, and what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for all new staff, and included in the ongoing education programme, as confirmed in the training records.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The policies reviewed acknowledge the organisation's responsibilities to Maori residents in accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers to receiving services are part of the organisation's documented policies.</p> <p>There is one resident who identifies as Maori at the time of audit. The resident has not identified any individual cultural needs. However, the caregivers, and registered health professions interviewed demonstrated good understanding of services that are in line with the needs of Maori residents and importance of whanau. The Lifecare Manager has long established networks with local providers of services to Maori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members verified, that they were consulted on their individual culture, values and beliefs and that staff respect these. Staff reported they received training in cultural awareness and this was evidenced in the education plan and training records sighted. A cultural safety policy is available for staff.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed expressed satisfaction with the standard of services provided to residents.</p> <p>The staff records reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries and the expected staff conduct. The family and residents reported they are happy with the care provided. Staff interviewed could detail the conduct that was expected of them.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from allied health professionals, such as the physiotherapist, occupational therapist, podiatrist and other specialist services. Applicable residents are referred to and seen by the community residential care pharmacists from the local DHB. The registered and enrolled nurses have access to regular ongoing education and records of this are maintained. Residents and family are invited to attend the residents' six monthly review meetings. Detailed assessment charts are used to document wounds and their</p>

		<p>progress in healing. The service has recently changed to an electronic medication management system (refer to Criterion 1.3.12.1).</p> <p>The general practitioner interviewed confirmed the service sought prompt and appropriate medical intervention when required and staff were responsive and implemented their medical requests. Staff interviewed stated end of life care was provided in a planned and coordinated manner and included, where relevant, input from the Hospice.</p> <p>Staff reported they receive in-service education on a regular basis on topics relevant to their role.</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>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process including via the six-monthly care review meetings.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> <p>Interpreter services are available and accessible via the DHB when required. Staff knew how to do so, although reported this was very rarely required. All current residents speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Northbridge is operated as a charitable trust with trustees who oversee all governance matters. There is a business plan which sets out annual objectives and strategies covering all aspects of service delivery. The day to day running and management of the facility is undertaken by the director who has been in the role for four years. The lifecare manager who has been in the role for over 30 years has responsibility for the care unit. The director reports progress towards meeting set objectives to the board monthly. Information reported includes all quality and risk data for the month.</p> <p>The lifecare manager reports to the director. There is a senior staffing team in place consisting of the lifecare manager, clinical manager (RN), assistant clinical manager (RN), infection control coordinator (RN), nurse educator (RN) and a contracted quality manager. The team has oversight of all clinical services to ensure delivery of care meets resident needs. The senior staffing team meet weekly and reporting is documented and discussed at minuted meetings. All the members of the management team have clear reporting lines which are identified in their job descriptions which show their authority, accountability and responsibilities.</p> <p>The organisation's philosophy, mission statement and values are clearly documented and both the</p>

		<p>director and the lifecare manager confirmed they underpin all planning processes.</p> <p>On the day of audit, the service had 89 residents consisting of 33 hospital, 11 dementia and 45 rest home level care residents.</p> <p>All the members of the management team maintain education and training related to their roles by attendance at conferences, in-service education, off-site training and via internet education.</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>During a temporary absence of management staff, the service ensures the day-to-day operation of the service is managed effectively and efficiently by staff who fill in. This is achieved by staff being upskilled via a progressive planning system to perform the roles they are asked to undertake. This was confirmed during staff interviews.</p> <p>During a temporary absence of the lifecare manager, the clinical manager undertakes the role and the most senior RN performs the clinical manager's role. During interview, the clinical manager discussed instances where this had recently occurred and they stated they were supported by all the members of the senior care team and that the director is available if required. The lifecare manager undertakes the director's role when required.</p> <p>Staff confirmed that there is no disruption to services when the facility manager is away.</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>Northbridge has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, restraint and complaints management. One month following admission, resident and family/whanau questionnaires are completed and information gathered is used to improve services to meet each individual resident's needs.</p> <p>Any issues or deficits identified in the quality data gathered have a corrective action plan put in place to address the situation. Corrective actions are developed and managed by the continuous improvement committee (CQI). Input for corrective action planning includes staff with speciality portfolios such as the infection control coordinator or the nurse educator. Quality information is shared with all staff via the handover process on each shift and/or by memos, in the staff communication folder, in meeting minutes and statistical data reporting. This was verified during staff interviews. All corrective actions are monitored and outcome results are documented. The board of trustees is kept informed of actions taken and results achieved.</p> <p>The policies reviewed reflected legislative and good practice requirements. All policies sighted were</p>

		<p>up to date and there is an electronic system to identify when each policy and procedure is due for review.</p> <p>Quality data is trended against previously collected data monthly, and an annual report is presented to the board of trustees. The quality and risk management system in place informs ongoing planning. The board quality reports identify the strategies that were put in place, the improvements made with clearly documented measurements to show sustained outcomes. Quality projects are documented with timelines and evaluations processes. One example relates to the introduction of an electronic medication system. Refer comments in criterion 1.3.12.1.</p> <p>Staff discussed examples of quality improvements made, such as the upgrade of fire evacuation signs throughout the facility.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed, monitored and managed via the health and safety committee. Staff confirmed that they understood and implemented documented hazard identification processes. Up to date hazard registers are kept for each area. The health and safety committee has a representative from each area of the workforce and includes a resident representative. At the monthly meeting, all hazards are reviewed to ensure they are managed to meet legislative requirements and that risks are reduced effectively.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse event reporting, as identified in policy, is implemented by the service. The management team confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations including the need to report pressure injuries under section 31 of the Health and Disability Services (Safety) Act 2001.</p> <p>Monthly statistics for incidents and accidents show the time the incident occurred, where it occurred, if any injury was sustained, and if so, the site of the injury, possible causes for the incident and if a medical review was undertaken. Statistical data is reviewed monthly against the previous 12-month period to identify any trends. This includes all falls data.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information, along with any corrective actions, is shared at staff meetings, as confirmed in minutes sighted.</p> <p>Documentation in residents' files and the 2016/2017 incident and accident forms reviewed identified that family/whanau are always notified and informed and they are also informed of any corrective actions put in place. This was confirmed during family/whanau interviews. Refer comment in criterion 1.2.3.6.</p> <p>The incident and accident form is only signed off as complete once all information is completed on the</p>

		<p>form. Serious harm incidents are reported to the board immediately.</p> <p>Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. All incidents are evaluated by the health and safety committee and the CQI committee to identify areas for improvement.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This was confirmed in the staff files reviewed. All roles have job descriptions that described staff roles, responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles. The orientation/induction process is individualised for each staff member and is a minimum of three days. A three-monthly appraisal is undertaken for all newly appointed staff and thereafter there are annual appraisals. Appraisals include feedback from the staff member and two colleagues who work in the same area prior to being undertaken by the team leader. Recently employed staff interviewed stated the orientation they undertook gave them a very good understanding of expected procedures and that they are not asked to perform any role they are unsure of. New staff are mentored by senior staff on each shift.</p> <p>Documentation in the staff files reviewed confirmed some competencies, such as medication management, fire and emergency and restraint are reviewed annually. There are three levels of medication competency one is for new staff and covers creams, eye drops and nebulizer use only. More senior health care assistants (HCAs) can check medications and team leaders, RNs and senior ENs undertake full medication competencies. There are 29 staff on the medication competency register.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and police checks.</p> <p>The education calendar sighted for 2016/2017 identifies that staff undertake training and education related to the roles they undertake. Topics covered in annual training and education relate to age care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site. All education is shown for each staff member and again collectively on a spread sheet for easy identification of when annual competencies are due. The RNs who work in the care areas hold current first aid certificates. Five RNs hold current interRAI competencies.</p> <p>Staff who work in the dementia care unit have either completed (13 staff) specific dementia care unit standards or are working towards gaining them. This process is overseen by the education officer and</p>

		<p>all data is kept up to date.</p> <p>Resident and family/whānau members interviewed, stated the staff present in a professional manner and are able to meet residents' needs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe appropriate care.</p> <p>There are dedicated staff who work in the secure dementia care unit. Staffing numbers increase to ensure adequate staff are in the unit as the number of residents increase.</p> <p>Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents' needs. There is at least one registered nurse on all shifts.</p> <p>Resident and family/whānau members interviewed stated all their, or their family member's needs have been met in a timely manner.</p> <p>The service has dedicated cleaning and laundry staff seven days a week. At the time of audit large laundry items are taken off site to a dedicated laundry service. The kitchen services are contracted. There are dedicated activities staff for 82 hours per week. A physiotherapy assistant works 15 hours per week.</p> <p>The lifecare manager, director and clinical manager work Monday to Friday and are on call. There is a dedicated nurse educator (RN) who works a minimum of 16 hours per week.</p> <p>The lifecare manager and the director have secretarial assistance Monday to Friday.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Demographic, personal, clinical and health information was completed in the ten residents' records randomly sampled for review. Records contain appropriate resident identification details. Clinical notes were current and integrated with GP and allied health professional notes included. Records were legible with the name and designation of the person making the entry identifiable. Medication records are now electronic.</p> <p>Archived records are held securely on site in two designated locations. Requested information was readily retrievable from the archives for all except one resident. For this one resident, only some of the required archived information was able to be located by staff. Staff advised this information may have been misfiled. This is not raised as a partial attainment as it did not reflect a systemic problem.</p>

		<p>Residents' records are held for the required period before being destroyed.</p> <p>No personal or private information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has an admission/enquiry form that records the pre-admission information. There is a resident's welcome information pack that is given to new admissions. The majority of residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. The Lifecare manager advises residents who live in the Northbridge Trust Retirement Village are prioritised for long term admission, and on occasions may be admitted for a short term / convalescent episode of care.</p> <p>Family members interviewed on this topic stated they were very satisfied with the pre-admission and admission process and the information that had been made available to them in a kind and timely manner. Records reviewed contained the information record, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>A record is maintained of all enquires and facility occupancy on a day by day basis.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort if appropriate. A transfer/discharge summary is completed when facilitating an urgent or planned transfer from Northbridge to acute care services, such as the DHB or infrequently to another aged residential care facility. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including a copy of the medication record (with any known allergies documented), and advanced directives is provided for the ongoing management of the resident. The 'yellow envelope' is used to ensure all applicable information is communicated. All referrals are documented in the progress records. Copies of discharge summaries from the DHB were located in applicable residents' files sampled.</p> <p>Residents and family interviewed who had experienced their relative being transferred to / from the DHB reported that they were kept informed before and after the transfer.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	FA	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. Medicine standing orders are current although are reported to be infrequently used now.</p> <p>Twenty one staff have full competency for medicine administration. Another eight staff have partial</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>competency and can administer eye drops, inhalers and topical creams only.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe medicine management was observed during the audit. Residents are informed of the medicine being administered and the purpose. Residents were observed to take the medicine before the staff member left. Administration was documented after the medicine was taken. The resident had the right to refuse offered medicines, and in this event the rationale was noted. Long term or short term changes in medicines prescribed are discussed with the resident or their family as verified by interview and documented in the resident files sampled.</p> <p>Medicines are locked away in secure cupboards. Medication trolleys are used for the medication round. Medicines that require refrigeration are stored in a separate fridge. Controlled drugs are managed in accordance with legislative requirements.</p> <p>A coloured resident photograph is on all individual resident's records reviewed.</p> <p>No residents are self-administering medications. Processes are in place to assess that the resident is safe to do so when applicable.</p> <p>There are documented competencies for nursing staff and the designated care staff approved to administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food services is provided on site by a contracted company. The relief chef / catering manager has worked at this facility for five years and is overseeing services in the long term manager's absence. The relief chef /manager is assisted by 15 staff (including staff who run the village cafe). Applicable staff have completed food safety training. The menu is a five week seasonal rotating menu. The current menu has been reviewed by a qualified dietitian. The service has an approved food safety plan which was reviewed by the Ministry of Primary Industries.</p> <p>All aspects of production, preparation, storage and disposal comply with current legislation and guidelines.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also readily available and used. This includes two residents who are requiring percutaneous endoscopic gastrostomy (PEG) feeding.</p> <p>Food and beverages are available 24 hours a day for residents in the dementia unit.</p>

		<p>Resident satisfaction with meals is verified by resident and family interviews and evaluated via a resident satisfaction survey. The main meal is provided in the evening.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is full occupancy, the enquirer is advised to ensure the prospective resident and family are able to find an appropriate care alternative, or, alternatively the enquirer is waitlisted for a bed to become available. The Lifecare manager advises she has never declined a referral.</p> <p>If the needs of an existing resident change and they are no longer suitable for the current services provided, a referral for reassessment to the NASC is made, and examples of this were sighted where residents have been reassessed as requiring a higher level of care. The resident is usually able to be relocated within the facility to ensure continuity of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All residents' records reviewed have a completed interRAI assessment completed by one of the five registered nurses who hold current interRAI competency. The interRAI assessments are used to identify residents who are at risk of falls, pressure areas, nutrition deficits or other risks. On occasions, a separate pressure area or falls risk assessment tool will be used to monitor resident risk. A schedule has been developed by the clinical manager for interRAI assessments on admission and for the six monthly reviews. This details all residents have a current interRAI assessment.</p> <p>Resident goals arising from the assessments are documented in the sampled files.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Care plans are in use to detail the long term and short term care required by individual residents. The care plans in the rest home area are not sufficiently detailed to guide care. Care plans by the GP, physiotherapist, occupational therapist, podiatrist and other visiting health professionals are documented in each resident's integrated clinical file.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. Interventions were provided to the sampled residents for wound care, pressure area management, changes in behaviour, pain, weight loss,</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>monitoring a resident after a fall and treatment of infections.</p> <p>The service has adequate wound care and continence supplies to meet the needs of the residents. Observations on the day of audit indicated residents were receiving appropriate care to meet their individual needs. Comprehensive shift handover processes aid communication on changing resident care needs. Residents and family members interviewed confirmed their care needs are being met in a timely, efficient manner.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is co-ordinated by an occupational therapist. Four other staff assist with developing and providing the activities programme. Eighty two staff hours are provided overall on a weekly basis for activities.</p> <p>The weekly activities plan is developed for rest home, hospital and the dementia service with some combined activities occurring. Copies of the programme are provided in advance to all residents and displayed throughout the facility. The display includes the days programme in larger print. Daily records of attendance are maintained. The activities staff meet weekly for planning and have catch-up / handover meetings on a daily basis.</p> <p>A social assessment and history is undertaken on admission to ascertain residents` needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident`s activity needs are evaluated six monthly as part of the six monthly care plan review.</p> <p>The planned activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual group activities and one on one activities as needed. Examples included music /entertainment sessions, arts and crafts, reading the newspaper, manicures, outings, and family events. Participation in any activity is voluntary. There is a church service occurring weekly on Thursdays for consenting residents. Communion is offered monthly.</p> <p>Wi-Fi is available to residents. There is a library on site and residents were sighted selecting reading material. Videos are available. A variety of board games and jigsaw puzzles are available throughout the facility. Residents can have a telephone in their room. A hairdresser is on site.</p> <p>Resident and family interviews demonstrated satisfaction with the programme and the range of activities offered. Residents interviewed confirmed they were satisfied with the programme and their participation is encouraged but not forced. The residents who did not participate in many activities, confirmed this was their choice and they were happy and independent in their room.</p> <p>Within the dementia unit the resident care plans include an activities plan that covers a 24 hour</p>

		<p>period. This is utilised by staff for resident's that wander at night. The activities programme in this area includes (but is not limited to) outings, movies, gardening, music activities, and art activities. A keyboard is present. Residents can participate in other activities within the facility with the direct supervision of staff. One resident was observed wiping down the meal tables and chairs and attempting to dust. Another resident was folding fabric. The secure outside garden area is accessible to residents who were observed walking throughout the garden area as desired.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>A range of appropriate assessment tools are available. Assessments are consistently completed for relevant aspects of care, including wound care, pressure injury management, pain assessment, monitoring bowel functions, and completing food and fluid balance charts when clinically indicated. Residents are weighted at least monthly and vital signs routinely recorded at the same frequency unless requested to be undertaken more frequently.</p> <p>The families reported that they can consult with staff and/or the GP if they have any concerns or there are changes in the resident's condition. They report that changes in the resident's condition are identified and followed up in a timely manner and this was sighted during audit. Family communications are detailed within the progress notes of the residents' files sampled and the six monthly resident review meetings.</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>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of any referrals were sighted in residents' records, for example, referrals to the physiotherapist, occupational therapist, radiology, speech language therapist, vascular services, ophthalmology, and DHB outpatient specialist services. The GP and nursing staff confirmed referrals are also generated to palliative care services, the dietitian, speech language therapist, the WDHB aged residential care pharmacist, and other health professionals when clinically indicated.</p> <p>The GP interviewed reported that appropriate referrals to other health and disability services are well managed at this service. The resident and family members interviewed identified they are always consulted and give agreement prior. On occasions residents or family have declined to have referrals made.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>Policy describes safe and appropriate storage and disposal of waste substances and this is implemented. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes. This includes two weekly recycling,</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>dedicated contractor management of medical waste, council pick up of plastics and contractor rubbish removal.</p> <p>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>	<p>FA</p>	<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 which expires 25 November 2017.</p> <p>There is a process in place to identify and manage reactive maintenance. There is also a long term maintenance plan in place which is managed at corporate level.</p> <p>The care unit shares the maintenance and gardening team with the village and external contractors are used as required. Electrical safety testing occurs annually when equipment checks are due. New equipment is checked according to manufacturer's specification. Clinical equipment is tested and calibrated by an approved provider at least annually and was last undertaken in March 2016.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions. Environmental audits are undertaken and corrective actions are put in place when required.</p> <p>Outdoor areas for residents have appropriate seating and shaded areas. This includes the secure dementia care unit which has a pergola with built in seating. Resident use of these areas was observed on the days of audit.</p> <p>Interviews with residents and family/whānau 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</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets, showers and bathrooms which are conveniently located in all areas. The four bedded rooms have two toilets and one shower in each room. Four bedrooms have a bathroom which can be used by two rooms as it is located between the bedrooms. Full ensuites are available in 77 of the bedrooms including the dementia care unit.</p> <p>There are four visitor and staff toilets, one has a full ensuite. These are clearly marked.</p>

requirements.		
<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>There are five bedrooms which contain four beds each, one bedroom which can be used as a double but is only used for couples, and the rest of the bedrooms are single occupancy. All the bedrooms are of a size which allows enough space for residents to mobilise safely with or without assistance. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings.</p> <p>Resident and family/whānau members interviewed confirmed they are happy with their personal space and state 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 adequate areas to meet their relaxation, activity and dining needs. There are five lounge areas throughout the complex. The dementia unit has a lounge/dining area which is furnished to show clear demarcation of each area. This can cater for up to 16 residents.</p> <p>There are two other dining areas, one for rest home and one for hospital level care. The service has a furniture replacement programme to ensure common areas and furnishings are kept in a good state of repair.</p> <p>Activities are undertaken in the lounge areas and there is a dedicated activities area.</p> <p>Residents and family/whānau voiced their satisfaction with the environment.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has documented procedures in place for cleaning and laundry tasks. The laundry is very well set out and has a clean and dirty entrance. The equipment is regularly maintained. Staff understand and use the various washing machines settings according to items being washed. The correct use of chemicals is monitored by the chemical supply company. Large laundry items are taken off site.</p> <p>The cleaners have specific trollies to carry all cleaning items and they are stored in secure areas when not in use. Chemicals are stored securely. Chemicals are labelled in bottles provided by the contracted company who supplies them. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference in all the area where chemicals are stored. Regular audits of chemicals and the safety data sheets is undertaken to ensure the complies with this standard.</p> <p>During interview, residents and family/whānau confirmed they were very happy with the cleaning and laundry services provided.</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 plan is reviewed annually as part of the quality process. This is one of the roles undertaken by the health and safety committee. Currently the service has a health and safety project underway which will result in every staff member attending up to date health and safety training which is to be presented by an off-site provider. The organisation have developed their own safety manual to reflect current legislation.</p> <p>Emergency fire equipment is checked annually by an approved provider, which last occurred in September 2016. There is an evacuation plan which was approved by the fire service in November 2007. There have been no changes to the facility footprint since this time. The secure dementia care unit has taken existing bedrooms with no changes to the exterior of the building being required. Fire cells have remained intact. Six monthly fire evacuations are undertaken with the last one occurring in December 2016. No follow up actions were required.</p> <p>Emergency supplies and equipment include food and water, first aid kits, outbreak supplies and a civil defence box. The contents are rotated regularly so that they do not expire. There is a dedicated storage room for civil defence supplies.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ and cooking. The emergency energy and utility sources were activated in a sudden power failure the day before the audit and the report sighted showed all systems functioned as they should. The service has a process in place for alternate food preparation and delivery should it be required. The medication system can be operated via the emergency power or can convert to manual use if there is a prolonged power cut.</p> <p>The security arrangements involve staff ensuring the doors and windows are locked upon dusk. An off-site security company patrols the grounds at random hours after dark. The service uses CCTV to monitor outside gates and entrances and the nurses' stations. Staff carry pagers at all times.</p> <p>Call bells are located in all resident areas including the secure dementia care unit. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. The lifecare manager conducts regular audits to monitor response times as part of the quality process.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>All resident areas have at least one opening window which provides natural light and ventilation. The facility has a mix of electric and water filled radiators for heating. Residents have heater in their bedrooms which allows them to control the temperature as they wish.</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>Residents confirmed that the facility is maintained at a comfortable temperature throughout the year.</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 provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control manual, developed at organisational level. The infection control programme is reviewed annually.</p> <p>Residents with a multi drug resistant organism (MDRO) have this clearly detailed in the care plan.</p> <p>A registered nurse is the designated IPC co-ordinator and works with the support of an enrolled nurse in the hospital wing and the clinical manager. The role and responsibilities of the IPC coordinator and the enrolled nurse is defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical manager and tabled monthly via the CQI meeting.</p> <p>Staff and residents are offered an annual influenza vaccination. Completed consent forms were sighted in a number of resident files sampled during audit. Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) is available and was observed to be in use. There have been no outbreaks of infection in 2016 / 2017 to date.</p> <p>Compliance with key aspects of policy is monitored via the internal audit programme.</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 infection prevention and control coordinator (IP&CC) has appropriate skills, knowledge and qualifications for the role, and has been in this role for about 18 years. The IP&CC attends regional infection prevention and control meetings as able and this was verified. If required expert advice can be sought from the community laboratory and/or the general practitioners, and the infection prevention and control team at the local DHB. The IP&CC is a member of a national infection prevention and control email forum and participates in reviewing and responding to issues raised. This was reported to be a useful forum to keep 'current' with the sector.</p> <p>The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The clinical manager is also available on a day to day basis for advice and support.</p> <p>The infection prevention and control coordinator confirmed at interview the availability of resources to support the management of any outbreak of an infection should this be required.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were current. Four copies of the policies are available for staff to access. These are located in the rest home wing, the hospital wing, house hold services, and in the manager's office. Where there is significant change in the content of a policy, or a new policy has been developed, staff are informed.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. This commences during orientation and has continued in the ongoing education programme. The education planner for 2016 has been implemented. The infection prevention and control coordinator provides education sessions and provides staff with topical questionnaires. A record was maintained of all infection control education provided.</p> <p>Education with residents is generally on a one-to-one basis and included mostly aspects of personal hygiene and the prevention of urinary tract infections.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility. This includes urinary tract infections, wound infections, eye infections, chest infections, multi drug resistant organisms, gastrointestinal and other infections. When an infection is identified a record of this is documented on the infection data form, and also detailed in the applicable resident's file. The two infection prevention and control staff review all reported infections and maintains a register including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. The GP interviewed confirmed being informed in a timely manner of residents with suspected infections.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff. New resident infections are communicated to staff via the shift handover and managers daily report.</p> <p>There have been no outbreaks of infection since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Northbridge has documented policy and restraint minimisation and safe practice guidelines in place. Policy describes enablers as equipment that limits freedom of movement, voluntarily used by a resident following appropriate assessment with the intent of promoting independence, comfort and safety. The use of enablers is voluntary and the least restrictive option to meet the needs of residents. At the time of audit there were seven residents with one enabler each and one resident with two enablers. They consisted of seven bedside rails and two chair lap belts. Residents use these to allow them to safely maintain their independence.</p> <p>There are three restraints in use, one resident has a bedside rail and one resident with a bedside rail and a chair lap belt. The service actively works toward promoting minimal use of restraint.</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>Restraint approval and process as set out in policy are implemented by the service. There is a restraint approval group consisting of the quality advisor (contracted), restraint coordinator (RN), lifecare manager and two RNs. The approval group meets monthly and all restraint is discussed with a full six monthly review being undertaken as part of interRAI assessment process. Resident notes are checked to ensure restraint or enablers are clearly shown on the care plan and it is noted if a family/whanau meeting is due so that a full restraint report can be presented. The restraint coordinator leads the team and this includes ensuring a review of policies and procedures, the adequacy of equipment, restraint documentation and staff training. A report covering all these topic is prepared monthly and presented at the CQI meeting. The responsibilities of the restraint coordinator are identified in the role description and the group have a documented process to follow.</p> <p>At the time of audit, the only approved restraint being uses are bedside rails and chair lap belts. The approval group, GP, resident and family/whanau are always involved in the decision to apply restraint. This was confirmed in two residents' files reviewed for restraint use.</p> <p>Restraint use is reassessed if the resident's condition changes to determine if restraint is still appropriate and/or six monthly during the resident's evaluation process. The resident and/or family/whanau sign to say this has been discussed at the six monthly evaluation.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in</p>	<p>FA</p>	<p>Restraint use is assessed for the need to put it into use and this is not done until the resident or family/whanau have signed a consent form. Assessment covers all aspects of this criterion including triggers, risks and benefits. If there is an incident related to restraint use a full re-assessment is undertaken and this would be discussed at the approval group. Ongoing assessment for restraint is</p>

relation to use of restraint.		undertaken during the interRAI assessment process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Approved restraint is only put in place once alternative interventions have been considered. These interventions are documented on the restraint approval forms. All restraint is approved by the restraint group prior to being used. Restraint is used for safety reasons only.</p> <p>The frequency of monitoring is undertaken according to the identified risk to the residents but never less than two hourly. The restraint coordinator determines the monitoring timeframes from the information gathered by assessment which includes staff concerns.</p> <p>All restraints are detailed in the restraint register to an auditable standard.</p> <p>Staff interviewed confirmed their understanding and knowledge related to safe restraint use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>All restraint use is discussed at the restraint group meeting with a monthly report and meeting minutes going to the CQI meeting. This information is then shared with all staff as restraint is a set agenda item on all meeting minutes sighted. The continued use of restraint is part of the resident's six monthly evaluation of care and this is documented via interRAI, and clearly shown on the resident's care plan. If restraint is no longer required, it is discontinued. Family/whanau are made aware of any changes in the need for restraint.</p> <p>The monthly meeting of the restraint approval group looks at all restraint in use and every individual resident is discussed. Staff restraint education occurs during orientation and ongoing at least annually. Restraint education is a compulsory educational subject for clinical staff at Northbridge. Education includes management of challenging behaviour and use of alternatives to restraint use.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The CQI committee review the restraint report monthly to identify any trends against previously collected data. An annual review of restraint use is presented to the lifecare manager and this covers all aspects required to meet this criterion. This report is presented at board level.</p> <p>Any issues that arise are followed up using the corrective action process. Only one corrective action has been raised since the previous audit related to a staff member using unauthorised restraint. All appropriate actions were documented and they show the outcome of the staff member being able to clearly verbalise their understanding of safe and appropriate restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Care plans are developed to detail the care required by residents in order to meet their individual goals. The care plans in the rest home were not always consistently detailed to described the care / interventions required. Despite this, the residents interviewed confirmed their needs were being met. The service has other communication mechanisms in place including shift handover that keep staff informed. The care plans for residents requiring hospital level care and dementia level care were more detailed.</p> <p>Short term care plans have been developed for short term events including wounds and pressure area and following repeat falls.</p>	<p>Three of four rest home resident long term care plans sampled did not contain sufficient details of the interventions required to meet the residents' goals.</p>	<p>Provide evidence that care plans are sufficiently detailed to guide service delivery.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality data is collected for all key performance indicators and trended against previously collected data. This information is presented to the CQI committee. The CQI committee take responsibility for projects, updating of documents in a timely manner, oversight of health and safety issues, staff education, quality statistics and any trends that need to be addressed, and all key performance indicator data collected. The analyses and evaluation of the results are well documented. The CQI committee plans and oversees all strategies put in place for any corrective actions or projects undertaken and this information and the analysis and outcome is shared with staff, residents, management and the board of trustees. Everyone is encouraged to have input regarding the actions taken. All input is taken into consideration and identified in the evaluation process and helps to inform outcome results. The success of the outcome is measured against the actions taken to identify if there have been sustained improvements in service provision and/or resident safety. This is confirmed in staff, resident and family/whanau interviews, who all commented that they feel valued and that their input is always readily accepted and acted upon by the lifecare manager.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a comprehensive, inclusive review process to encompass service providers, residents and family/whanau input and feedback to corrective actions put in place. All feedback is taken into account when measuring the level</p>

			of success of the corrective actions taken from across all areas of the service delivery.
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	CI	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, medicine reconciliation, processes when an error occurs. The sighted policies meet the legislative requirements of best practice</p> <p>An electronic medicine management system is being utilised. Additional tablet resources were purchased for use. The medicine records randomly reviewed on the electronic system used have been reviewed by the GP at least three monthly. All prescriptions sighted were accurately documented by the GP and checked by the pharmacist. Any allergies/sensitivities are flagged on this system.</p> <p>The service has moved to use of an electronic medicine management system since the last audit and implementation has been evaluated. Staff were provided with training on using the new system. Feedback from staff notes the system is user friendly. The prescribers can remotely prescribe or amend medicine records following conversations with the RNs (e.g., for a resident with an infection). This has enhanced the timeliness of prescribing occurring and reduced the use of verbal orders. Once staff were familiar with using the new system, they report the time spent undertaking the medicine rounds has reduced enabling the nurses more time to complete other activities. Medicine records are legible and clear. There are no issues reading or interpreting the general practitioner's orders. Orders and re-orders of medicine can be done at the time medicines are administered rather than being a separate task following the medicine round. There is automatic transfer of medicine record changes to the pharmacy reducing potential delays or errors in this process. The use of the dash board function has allowed at a glance a review to ensure medicine records are reviewed by the general practitioner at least three monthly. Resident refusal of medicines is easily traceable as is the use of pro re nata medicines for discussion at GP reviews and the six monthly care review meetings. The general practitioner advises being electronically alerted of residents who do not have indications noted for pro re nata medicines. Changes to a resident's medicine records can be more readily updated post discharge from the HDB hospital in the event changes are required. The number of pharmacy and facility medicine errors has reduced.</p>	The service has moved to use of an electronic medicine management system that has improved medicine management practices and enhanced resident safety.

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End of the report.