

St Johns Hill Healthcare Limited - St Johns Hill Healthcare

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:	St Johns Hill Healthcare Limited
Premises audited:	St Johns Hill Healthcare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 July 2017 End date: 5 July 2017
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:	47

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

St Johns Hill Healthcare in Whanganui provides rest home and hospital level care for up to 56 residents. The service is a family owned business and a general manager oversees all operations, with a facility manager and a clinical leader who manage the day to day operations of the service. Residents and family/whānau spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

This audit has resulted in continuous improvement ratings in staff training, staff orientation, restraint minimisation, emergency planning, the infection prevention and control programme and the food services. There is one area identified that requires improvement relating to the consistency of the documented records.

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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Residents and their family/whānau are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families/whānau is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and family/whānau with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Continuous improvement has occurred with the development of electronic data collection enabling better

reporting and monitoring. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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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Access to the service is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised based on a range of information and accommodate any new problems that might arise. Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents reported 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 facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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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Restraint use has been eliminated from the facility and all other alternatives are explored instead. Families confirmed their satisfaction no restraints or enablers are used.

The organisation has implemented policies and procedures that support the minimisation of restraint and a comprehensive assessment, approval and monitoring process with regular review occurs, to comply with the Standard.

Use of enablers is discouraged for the safety of residents. In response to individual requests of voluntary enabler use education is provided to residents. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and the restraint-free environment.

It is the goal of the facility to have no enablers or restraints in use, and this was the case at the time of audit.

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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results are reported and benchmarked with other providers. Follow-up action is taken as and 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	44	0	1	0	0	0
Criteria	6	86	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 organisation has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records sampled.</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>Nursing and care staff understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. The resident's records sampled show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents' record. Staff were observed to gain consent for day to day care.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Residents and family/whānau were aware of the Advocacy Service, how to access this and their right to have support persons.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The organisation has unrestricted visiting hours and encourages visits from residents' family and friends. 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>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 24 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow-up and improvements have been made where possible. The facility manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family/whānau 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 at resident meetings. The Code is displayed throughout the facility, together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with</p>	<p>FA</p>	<p>Residents and family/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents reside in private rooms, no rooms are currently shared; there is a shared room policy in place should this occur. Residents are</p>

<p>respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>encouraged to maintain their independence by participation in community activities. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and as part of the in-service education programme.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents who identify as Māori stated the facility acknowledges and respects their individual cultural needs.</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>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans sampled. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family/whānau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated understanding of the process they would follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The GP expressed high praise for the clinical knowledge and skill of the nursing staff.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the restraint minimisation and infection prevention and control programmes and quality initiatives that have been implemented in the food services.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whānau reported they were kept well informed about any changes to their/their relative's 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff demonstrated knowledge of how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly and quarterly reports to the owners showed adequate information to monitor performance is reported, including financial performance, emerging risks and issues.</p> <p>The service is managed by an onsite facility manager with oversight by a general manager (GM), both of whom hold relevant qualifications and have been in the role for more than three and a half years. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. Both the GM and facility manager confirm knowledge of the sector, regulatory and reporting requirements and maintains currency through their nursing registration and involvement in the sector.</p> <p>The service holds contracts with the DHB for hospital level care, rest home and intermediate care respite, complex medical conditions, and palliative care. Twenty-one residents were receiving services under the hospital level care contract and 26 under the rest home care contract at the time of</p>

		audit.
<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>When the facility manager is absent, the clinical nurse leader carries out all the required duties under delegated authority with the support of the general manager. During absences of key clinical staff, the clinical management is overseen by the facility manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, regular risk register review and risk mitigation strategies.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting, nurses' quality meeting and facility team meeting which all staff can attend. Staff reported their involvement in quality and risk management activities through incident reporting, audit activities, hazard identification and meeting attendance. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a satisfaction with services provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Continuous improvement is evident throughout the functions of all resident, staff, management and governance meetings. Information and quality data is shared openly and corrective actions developed collaboratively at every level of the organisation. Opportunities for improvement are pursued by residents, families, staff, and managers alike and evaluation of all aspects of residents' well-being</p>

		occurs to ensure quality safe care. The recent implementation of an electronic quality data system has enabled ease of data reporting, analysis, and sharing of data. Evaluation of the system has already resulted in improvements to the system.
<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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported within an electronic system. Results and corrective actions are reported on at each of the regular meetings to staff, managers and the owners.</p> <p>The GM and facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been and /no notifications of significant events made to the Ministry of Health, since the previous audit.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation after a three-week period and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff members are internal assessors for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Continuous improvement was evident in the areas of orientation and ongoing training with the development of a comprehensive orientation self-learning package and the development of a training coordinator role for the orientation of carers. This senior carer works alongside new carers as an initial 'buddy' and then as an ongoing mentor to ensure best practice is provided. The role has been developed to include assessing against the training modules and a weekly health and well-being 'drop-in' session is provided to further support all carers. Any decline in service delivery results in immediate</p>

		reinstatement of the buddy system with the training coordinator. Carers demonstrated a high level of engagement and satisfaction with their orientation and ongoing training opportunities. Evaluation of the role and orientation package has indicated staff are providing a higher standard of care to residents because of their orientation.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the hospital.</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>	PA Low	<p>All necessary demographic and personal information was completed in the residents' files sampled for review. There were some inconsistencies in what was recorded in the residents' clinical records (refer to 1.2.9.1). Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information and other electronic records. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident 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>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. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files sampled contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a transfer record to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example sampled of a patient recently transferred to the local acute care facility showed the organisational processes were followed. Family of a resident who had a recent admission to hospital reported being kept well informed during the transfer of their relative.</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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. Staff were observed in the rest home and hospital areas and demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medicines against the prescription. All medicines sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures sampled for the medicine fridge and the medicine room were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine charts.</p> <p>There were residents who self-administered some of their medicines at the time of audit (such as inhalers). Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medicine errors.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by the kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. The service has implemented a quality improvement project with the food services (refer to criterion 1.3.13.1).</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as, pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments. There was one file in the sample where the clinical staff were not able to gain access to the interRAI within three weeks of the resident's admission, this was not reflective of a systemic issue. Residents and family/whānau confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Residents' files sampled reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans sampled.</p> <p>Residents' files evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner and that medical orders were followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</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 provided seven days a week for the hospital level of care residents and five days a week for the rest home level of care residents. There is a trained diversional therapist and two activities coordinators who assist with the activities programme.</p> <p>A social/diversional therapy assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly sampled to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and family/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme is of interest to them.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months or as residents' needs</p>

<p>are evaluated in a comprehensive and timely manner.</p>		<p>change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and post discharge from the acute care hospital. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and family/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the dentist, oncology and general surgery. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated health and safety staff member who has completed a two-day health and safety training programme provided by an external training provider. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness expiring on 3 July 2018 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts were made to ensure the environment was hazard free, that residents were safe and independence was promoted.</p>

		<p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes most rooms having a private ensuite and the availability of a visitors' toilet. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry, or by family members if requested. Dedicated laundry staff and care staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p>

<p>services appropriate to the setting in which the service is being provided.</p>		<p>There is a small designated cleaning team who have received appropriate training. These staff are undertaking the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and resident/family satisfaction.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides staff in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 2004. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 23 March 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the requirements for the 56 residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security checks are performed at night.</p> <p>Continuous improvement is evident in the facility's emergency planning. Following regional flooding in 2015 evaluation of the emergency systems was performed in conjunction with the DHB and then at facility level. This review resulted in the development of a set of easy to comprehend laminated photographs of all switches and equipment RNs and care staff may need to access in an emergency, without the assistance of maintenance staff. Examples included, turning on the generator, to provide power to the laundry, kitchen and lift or accessing the external water storage. The emergency folder was readily accessible in reception and is regularly evaluated as part of the quality and risk system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many of the corridor have doors that open onto an outside garden or small patio area. Heating is provided by radiators in residents' rooms and in the communal</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The organisation implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from an external aged care consultant. The infection control programme is reviewed at least annually.</p> <p>A registered nurse is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general management team, and tabled at the staff committee meeting. This meeting includes the management team, care staff, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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 has appropriate skills, knowledge and qualifications for the role. The infection control coordinator has undertaken education in infection prevention and control and attended relevant study days, with verified training records sampled. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection</p>

<p>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>control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When there is an increased number of infections, there is evidence that additional staff education has been provided in response. An example included when there was an increase in urinary tract infections for residents who have indwelling catheters.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance 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 long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The infection control coordinator reviews all reported infections and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</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 via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to management and staff. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>There have been no reported outbreaks of infections. One resident was discharged from the acute care hospital with an infectious diagnosis, St John Hill staff implemented isolation and transmission based precautions when the resident returned to the service. The infection did not spread to any other</p>

		<p>residents or staff.</p> <p>The service has implemented a quality project related to minimising infections (refer to criterion 3.5.7).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints or enablers. A similar process is followed for the use of enablers as is used for restraints, when used.</p> <p>Restraint use has been eliminated with all other alternatives explored instead. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p> <p>Prior to eliminating all restraints, the restraint committee undertook six-monthly review of all restraint use which included all the requirements of this Standard. Six monthly restraint meetings and reports are completed and any emergency one off incident of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of any incident of restraint use, including competency of staff, whether all alternatives to restraint had been considered, and the appropriateness of restraint / enabler. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with carers, RNs, the facility manager and the restraint coordinator confirmed that the use of restraint and enablers has been eliminated over the past eleven months.</p> <p>Continuous improvement is evident in restraint minimisation through the decision a year ago, to eliminate the use of restraints or enablers within the facility. The implementation of this goal involved both staff, residents and their family members and the 'buy-in' of the owner. Equipment changes included; removing all bedside rails, purchasing new additional equipment, such as low-low beds, 'landing strips' and sensor mats. Investment in education of residents and their families in the alternatives to restraints and enablers and staff training in de-escalation techniques all contributed to the restraint free environment. In addition, RNs, carers and diversional therapy staff are attending the 'Walking in their shoes' education available through the DHB. Staff have an excellent understanding of safety requirements for residents and the importance of finding alternatives to using restraints or enablers. Evaluation of the restraint free status occurs regularly as part of the Standard requirement and is celebrated by the staff.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	The resident files reviewed had several forms related to bowel management that were not fully completed. One of the files had inconsistencies in the interRAI assessment compared to what was in the care plan, one file did not have the care evaluation clearly documented and one file did not have the long-term care plan recorded within three weeks of the resident's admission. The recording of the medication fridge temperature on the upper level of the facility have been inconsistently documented. Individually these issues did not constitute systemic issues within the care planning process, though combined, there is an overall improvement required to ensure information is recorded accurately and in a timely manner.	Forms related to resident care/interventions and environment recordings are not always fully or accurately completed.	Information is entered consistently and accurately into the clinical records. 180 days

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
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Continuous improvement is evident throughout the functions of all resident, staff, management and governance meetings. Information and quality data is shared openly and corrective actions developed collaboratively at every level of the organisation. Opportunities for improvement are pursued by residents, families, staff, and managers alike and evaluation of all aspects of residents' well-being occurs to ensure quality safe care. The recent implementation of an electronic quality data system has enabled ease of data reporting, analysis, and sharing of data. Evaluation of the system has already resulted in improvements to the system.	The achievement of the quality assurance data project is rated beyond the expected full attainment. The quality improvement project sighted had a documented review process which included analysis and reporting of findings to management and staff. Documentation evidences action taken based on findings and improvements to the system. Staff and resident satisfaction with the quality data reporting has been measured as part of the review process. Residents and family interviewed reported increased satisfaction with the quality of the data being shared.
Criterion 1.2.7.4 New service providers receive an	CI	Continuous improvement was evident in the areas of orientation and ongoing training with the development of a comprehensive orientation self-learning package and the development of a training coordinator role for the orientation	The achievement of the orientation project is rated beyond full attainment. Evaluation of the role and orientation package included analysis and reporting of findings to management and staff. Documentation

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>of carers. This senior carer works alongside new carers as an initial 'buddy' and then as an ongoing mentor to ensure best practice is provided. The role has been developed to include assessing against the training modules and a weekly health and well-being 'drop-in' session is provided to further support all carers. Any decline in service delivery results in immediate reinstatement of the buddy system with the training coordinator. Carers demonstrated a high level of engagement and satisfaction with their orientation and ongoing training opportunities.</p>	<p>evidences action taken based on findings indicates staff are providing a higher standard of care to residents earlier in their employment.</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>The service has conducted quality improvement projects into the presentation of the textured modified food and the plating presentation of other foods, increasing variety of the foods and fluids. The residents and family/whānau have been involved in the review and suggestions for the meals. The project included the analyses and reporting of satisfaction surveys and feedback related to the food. The outcomes include residents' increasing satisfaction with the variety of food, more choices, the residents choosing their meal options each day, the presentation and plating of normal and special diets (including textured modified foods), and the reduced number of residents that have triggers for potential malnutrition. The analysis for the improved health outcomes data for April 2017 recorded that no residents have triggers for potential undernourishment.</p>	<p>The achievement of the quality projects related to the presentation and variety of foods and fluids is rated beyond the expected full attainment. The quality improvement projects sighted have a documented review process which includes analysis and reporting of findings to management, staff, residents and family/whanau. The projects documentation evidences action taken based on findings and improvement to the presentation and variety of food and fluids on offer. Resident safety and/or satisfaction has been measured because of the review process, which evidences positive outcomes, increasing resident satisfaction, and reducing the number of residents that have triggers for potential undernourishment. Several of the residents and family/whanau interviewed reported that the meals are of a 'restaurant quality' and that the presentation of the textured modified food is appetising.</p>
<p>Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main</p>	<p>CI</p>	<p>Following regional flooding in 2015 evaluation of the emergency systems was performed in conjunction with the DHB and then at facility level. This review resulted in the development of a set of easy to comprehend laminated photographs of all switches and equipment RNs and care</p>	<p>The achievement of the emergency planning for energy and utility failure is rated beyond the expected full attainment. The laminated instructions sighted had been through a review process which included analysis and reporting of findings to management and</p>

supplies failing.		staff may need to access in an emergency, without the assistance of maintenance staff. Examples included, turning on the generator, to provide power to the laundry, kitchen and lift and accessing the external water storage.	staff. Documentation evidences action taken based on findings and improvements to the system. Increased resident and staff safety with the improved information has been measured as part of the review process. Staff interviewed reported increased satisfaction with the quality of the information available to them in an emergency.
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The service has conducted several quality improvement projects in 2016/ 2017 related to reducing the overall number of infections and infections with residents who have an indwelling catheter inserted. The projects sampled demonstrated an analysis of the number of infection prior to the project, the benchmarking threshold level of infections, and developed strategies for reducing infections. The strategies include staff and resident education, development and implementation of a catheter care competency and updating of policies and procedures. Resident satisfaction was measured as part of the review, which included resident and family satisfaction and improvements in the resident's wellbeing because of reduced infections.</p> <p>The outcomes of the project recorded reductions in infections in the eight-month period since the implementation of the new processes (these residents previously had frequent infections). All the RNs have completed the catheter competency and the care staff have attended the catheter care education. The reporting of the analysis and outcomes of the project were presented to the management team, the nurses and general staff meetings. The benchmarking results record that the facility is below the benchmark threshold for infections. The service has no use of prophylactic antibiotics and one resident who previously had regular infections has not required antibiotics for 10 months and the resident's kidney function has improved. This resident's overall wellbeing has improved with reduced confusion and restlessness. The resident's family/whanau report that they are highly satisfied with the</p>	<p>The achievement of the infection prevention and control project related to reducing infections with residents who have an indwelling catheter is rated beyond the expected full attainment. The quality improvement projects sighted have a documented review process which includes analysis and reporting of findings to management and staff. The projects documentation evidences action taken based on findings and improvement to service provision. Resident safety and satisfaction has been measured because of the review process, which evidences positive outcomes in reducing infections and increasing residents' wellbeing.</p>

		improvements they have sighted in the family member over the 10-month period.	
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>The last resident to use cot sides did so voluntarily, as an enabler and at their insistence, for their comfort and sense of security. This person was educated, encouraged and supported over a period, to feel safe and secure with alternative supports. The resident and family expressed satisfaction that cot sides are no longer being used.</p>	<p>The achievement of the enabler elimination project related to the elimination of enabler use by the only resident using an enabler is rated beyond the expected full attainment. The quality improvement project sighted had a documented review process which included analysis and reporting of findings to management, staff, residents and families. The project documentation evidenced actions taken based on findings and improvement to service provision. Resident safety and satisfaction has been measured because of the review process, which evidences positive outcomes in staff and resident understanding of the need to seek alternatives to the use of enablers. The enabler and restraint-free environment has increased residents' wellbeing and staff job satisfaction.</p>

End of the report.