

Oceania Care Company Limited - Takanini Lodge

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 Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	Takanini Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 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:	86

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

Takanini Lodge can provide rest home, hospital and dementia level care for up to 91 residents. Occupancy on the day of the audit was 86. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures, supporting documents, resident files, staff files and observations, interviews with residents, family, management and staff and a general practitioner.

There are no requirements for improvement and one recommendation for continuous improvement relating to service delivery around falls management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible in information packs and displayed within the service.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

Staff demonstrate an understanding of residents' rights and their knowledge is incorporated into their daily work and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body and is responsible for the service provided at Takanini Lodge. The business and care manager is appropriately qualified and experienced. The acting clinical leader is responsible for oversight of clinical care.

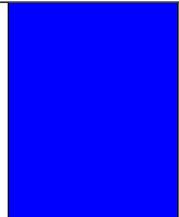
Oceania Healthcare Limited has a documented quality and risk management system that supports the provision of clinical care and support at the service. Quality and risk performance is reported through meetings at the facility and is monitored by the organisation's management team through the business status and regional operations manager reports. Policies are reviewed at support office. Benchmarking reports include incidents/accidents, infections, complaints and clinical indicators with trends analysed to improve service delivery.

The service implements human resource policies relating to recruitment, selection, orientation, induction, staff training and staff development. Professional qualifications are validated and registration with professional bodies are verified. A documented

rationale for determining staffing levels and skill mix is implemented to reflect the resident's acuity to ensure the correct allocation of clinical staff is applied. The service has an annual training plan to ensure ongoing training and education for all staff members. Four registered nurses have completed interRAI training and one is currently in training.

The business and care manager and acting clinical leader are completing on-call duties on a rotational basis and are available after hours if required. Care staff, residents and family reported that there is adequate staff available. Residents' information is recorded accurately and in a timely manner. All residents' information is maintained in a secure environment with no public access.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility supported by care and allied health staff (podiatrist; physiotherapist; pharmacist) and a contracted general practitioner. On-call arrangements for support are in place. Shift handovers and communication sheets guide continuity of care.

Person centred care plans are individualised, based on a comprehensive and integrated range of clinical information. Short-term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well

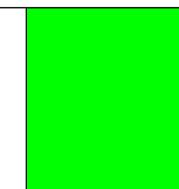
informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, 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. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen is well organised, clean and meets food safety standards. 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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Building and plant comply with legislation, with a current building warrant of fitness displayed. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

All laundry services are completed by another Oceania Healthcare Limited facility. The clean laundry is then delivered to Takanini Lodge on a daily basis. Cleaning processes and programmes are in place. The service is fit for the purpose, including the external environment.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed.

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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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and eight restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Enabler use is voluntary for the safety of residents in response to individual requests. Staff receive training at orientation/induction and thereafter annually, including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 is led by a registered nurse who has completed infection control education relevant to this role. There are terms of reference for the infection control committee which meets monthly. Specialist infection

prevention and control advice is able to be accessed from the district health board, laboratory microbiologist; and other specialists if needed. The programme is reviewed annually.

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, analysed, trended, benchmarked and results are reported through all levels of the organisation. 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	1	49	0	0	0	0	0
Criteria	1	100	0	0	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 provides education to staff on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their orientation to the service and through the training programme. Staff confirmed their understanding of the code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. Education relating to the Code and complaints was last provided by the Health and Disability Advocacy Service, with residents and families invited to attend.</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</p>	FA	<p>The service has policies and systems in place to support residents, and where appropriate their family, to provide information to assist them in making informed choices and giving informed consent. Care staff interviews confirmed staff training is provided to ensure policy and systems are adhered to. The business and care manager confirmed informed consent is discussed and documented at the time the resident is admitted to the facility and reviewed when required.</p> <p>Family interviews confirmed they have been made aware of and understand the principles of informed</p>

<p>informed choices and give informed consent.</p>		<p>consent. Copies of legal documents such as enduring power of attorney (EPOA) for residents are retained at the facility where residents have named EPOAs (sighted in residents' files). The policy and procedure includes guidelines for consent for resuscitation/advance directives.</p> <p>A review of files noted that all had appropriately signed advance directives. The general practitioner (GP) makes a clinical decision around resuscitation and ongoing treatment for residents who are not able to make an advance directive (and have no advance directive documented in the past). The advance directive is discussed with the family and/or EPOA prior to the doctor signing the form.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family reported that they are encouraged to visit at any time.</p> <p>Residents confirmed they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The activities programme includes visits to areas in the community, for example, local eateries and clubs. The service also encourages the community to be a part of the residents' lives with visits from entertainers and community groups.</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 policy and procedures are in line with the Code and include timeframes for responding to a complaint. Complaint forms are available at the entrance and in other communal areas within the service. The complaints register is current and includes: the date the complaint was received; the source of the complaint; a description of the complaint; actions taken; and the date the complaint was resolved with sign-off from the business and care manager.</p> <p>Review of the complaints management process confirmed complaint management processes are embedded in practice. There was evidence of staff training on complaints management. Residents and family members confirmed they knew the process and felt comfortable to complain.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code and information on the advocacy service is available and displayed in English and te reo Māori in the foyer and other areas throughout the facility. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Interviews confirmed explanations regarding their rights occurred on admission. The business and care manager (BCM), acting clinical leader and registered nurses (RN) follow up with a discussion with residents and families during the admission process.</p> <p>The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the range of services. This is included in the service agreement and admission agreements. Residents interviewed confirmed they had access to an advocate if needed.</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>	<p>FA</p>	<p>The service philosophy promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code.</p> <p>Staff receive annual training on abuse and neglect and can describe signs. The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. There were no documented incidents of abuse or neglect in the business status reports or on incidents reviewed in resident files. Residents, staff, family and the general practitioner confirmed that there is no evidence of abuse or neglect. Abuse and neglect training is included in the mandatory training programme for staff, which was evidenced in the staff training records. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes residents' beliefs and values. Care plans are completed with the residents and family members. Interventions to support these are identified and evaluated.</p> <p>Staff were observed knocking before entering residents' rooms and closed doors while attending to residents' needs. Residents were observed being treated with respect by care staff during this audit and addressed residents using their preferred names. Activities and outings in the community are encouraged and are part of the residents' activities plan. Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori</p>	<p>FA</p>	<p>The service implements the Māori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori Health Plan. The diversional therapist and activity assistants complete cultural assessments on</p>

have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		admission and updates six monthly. There are six residents who identify as Māori living at the facility, with cultural assessments completed. Interviews with residents and family confirmed their cultural needs are being met. Cultural training for staff has been provided.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs. The service had a variety of residents from other cultures who during interview confirmed that their cultural needs are met. Staff and family interviews confirmed that the service take additional care in making sure cultural needs of residents are identified and met. The auditors verified cultural assessments for residents.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The organisation has policies on discrimination, coercion, harassment, sexual, financial, or other exploitation, which include actions to be taken if there is inappropriate or unlawful conducts and is part of the mandatory staff training programme. Staff files reviewed included copies of the code of conduct that all staff are required to adhere to. Conflict of interest issues including the accepting of gifts and personal transactions with residents are included in the staff training, policies and procedures. Expected staff practice is outlined in job descriptions and employment contracts, which were reviewed on staff files. Residents and family interviewed reported staff maintain appropriate professional behaviour.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	A staff education programme is implemented and staff could describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses and general practitioner. Consultation is also available with health professionals and specialists in the region, with staff able to describe how and when they can make contact. Residents and families interviewed expressed a high level of satisfaction with the care delivered.
Standard 1.1.9: Communication Service providers communicate	FA	Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>procedures guided staff on the process to ensure full and frank open disclosure was available. Family members confirmed they are informed if the resident has an incident/accident or has a change in health or needs. Family contact is recorded in residents' files.</p> <p>Interviews with residents confirmed they are aware of the staff who are responsible for their care and staff communicate effectively with them.</p> <p>Interpreting services are available from the district health board. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Oceania Healthcare Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager (BCM) provides monthly status reports to the support office. These reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators</p> <p>The BCM is responsible for the overall management of the service and is supported by the regional clinical and quality manager. The BCM has worked in the organisation for 15 years and has a business management background. The acting clinical leader is responsible for all clinical matters and their appointment is full time. The acting clinical leader has worked for the organisation for several years.</p> <p>The facility can provide care for residents requiring rest home, hospital or dementia level of care. Occupancy during the onsite audit was 86 residents. On the day of audit there were 27 residents requiring rest home level of care, 39 residents receiving hospital level of care and 20 residents receiving dementia level of care. Of these residents, there are 2 under the young person disability contract for residents under 65 years old.</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</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation for continuity of service delivery, should the BCM be absent. The regional clinical and quality manager stands in for the BCM with clinical overview by the acting clinical leader. The service also has input from the operational manager who is currently the general manager.</p>

consumers.		
<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>Takanini Lodge uses the Oceania Healthcare Limited quality and risk management framework to guide their practice. Policies are reviewed by the support office with input from the regional clinical and quality manager and BCM. Policies are current and align with the Health and Disability Sector Standards, legislation and best practice guidelines. New and revised policies are presented to staff at staff meetings and are available in hard copies. The service has a documented control system to manage new and obsolete policies.</p> <p>The service has monthly staff, registered nurse, quality, health and safety, infection control, restraint, and residents' meetings. All meetings have a framework which is reflected in the meeting minutes, with timeframes and designated roles identified to implement any changes in practice and outcomes. The meeting minutes and communication with staff, family and residents reflect all aspects of quality improvements.</p> <p>The quality improvement plan with quality objectives was reviewed during the audit which guides the quality programme. Family/residents and staff satisfaction surveys are completed as part of their audit programme and results of the survey were reviewed. There was evidence of changes being implemented as a result of the surveys.</p> <p>The service has a hazard register that identifies health and safety risks. There is a designated health and safety officer who oversees all aspects of health and safety and is supported by the BCM and health and safety committee, who meet monthly. A health and safety manual is available that includes relevant policies and procedures. There is a designated health and safety board in the staff room which is updated with new and relevant documentation.</p> <p>Service delivery is monitored through complaints, incidents/accidents and implementation of an internal audit programme, with corrective action plans and evidence of issues completed. All incidents are reviewed by the BCM with input of the acting clinical leader where needed.</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</p>	FA	<p>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the BCM. Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Policy and procedures meet the terms of essential notification reporting for example: health and safety, human resources and infection control.</p>

<p>choice in an open manner.</p>		<p>The BCM confirmed during interview that they are aware of their responsibilities relating to essential notification. The Ministry of Health have been informed of the change in the clinical management role and the appointment of the acting clinical leader.</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>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments.</p> <p>Copies of annual practising certificates are reviewed for all staff that require them to practice and are current. The acting clinical leader, with the assistance of the BCM and regional clinical and quality manager, is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The BCM advised that staff complete orientation and induction at employment. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period.</p> <p>Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments. The service has four RNs who have completed interRAI training and there is one RN currently enrolled to do the course. Staff working in the dementia unit completed appropriate training as required by the contractual agreement with the district health board (DHB).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has staffing policies that guide the process. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. The BCM uses a matrix system that identifies the number of hours required to the resident acuity ratio. On the day of the audit the numbers of hours for the past duty roster exceeded the number required. There are 73 staff, including the management team, clinical staff, a diversional therapist, two activity staff and household staff. There is a registered nurse on duty at all times. The BCM and the acting clinical leader take turns at being on-call for a week. This on-call after-hour service</p>

		<p>is provided 24/7.</p> <p>The service has 10 dual purpose beds. The service is divided into two areas called hospital one and hospital two, with both areas having rest home and hospital beds. Hospital 1 has 30 residents; 18 at hospital and 12 at rest home level of care. Hospital 2 has 36 residents; 21 residents are receiving hospital level of care and 15 receiving rest home care. Residents with higher care needs are placed in 'high traffic areas' and have 'intentional rounding' (where staff complete regular physical checks) included in their care plans. Residents who are at rest home level of care are placed closer to social and communal areas.</p> <p>Activities are provided in both hospital areas. Residents who are mobile (rest home level and hospital level of care), attend activities in the communal areas specifically used for activities. Residents who are not independent attend small groups of activities provided in both hospital areas, specifically planned for them or one-on-one activities with the activity staff, as appropriate for the individual resident. All residents are engaged in the activities programmes. Activities in dementia care are specific to the needs and abilities of the residents with 24 hour activities identified for the management of challenging behaviour.</p> <p>Staff provide the skill mix needed to ensure appropriate services to all residents. Observation of residents and interviews with residents and family confirmed their needs are being met during service delivery. Residents and families interviewed confirmed staffing is adequate to meet the residents' needs. Staff confirmed that they have sufficient time to complete cares scheduled.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff; information containing sensitive resident information is not displayed in a way that it could be viewed by other resident's medical care or members of the public. Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Approved abbreviations are listed.</p> <p>The service retains relevant and appropriate information to identify and track residents' records. There is sufficient detail in resident's files to identify resident's ongoing care, history and activities. Documentation in individual resident files demonstrated service integration. The resident's national health index number, name, date of birth and general practitioner are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is</p>	<p>FA</p>	<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</p>

<p>facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>families are encouraged to visit the facility prior to admission and meet with the business and care manager. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the NASC service and/or the general practitioner 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. Records reviewed contained completed demographic details, assessments, copy of any enduring power of attorney documents, ethnicities and signed admission agreements in accordance 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 coordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow transfer envelope system' to facilitate transfer of residents to and from acute care services. There is open disclosure through effective communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, are provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility at the DHB showed on the family communication record that the family were 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 the audit. The staff observed 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. Twelve registered nurses and two senior healthcare assistants have completed competencies for medication management and the training records were reviewed.</p> <p>Medications are supplied to the facility in a pre-packed format from a contracted pharmacy. These medications are checked by the receiving registered nurse against the prescriptions. All medication sighted were within current use by dates. Clinical pharmacist input is provided six monthly and audits are undertaken.</p> <p>Drugs are stored securely in accordance with requirements. Drugs are checked by two registered nurses for accuracy in administration, where required. The drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p>

		<p>The records of temperatures for the medicine fridge was within the recommended range.</p> <p>Prescribing practices and all requirements for pro re nata (PRN) medicines are met. The required three monthly GP reviews are consistently recorded on the medicine record electronically.</p> <p>There were two rest home level residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the acting clinical leader and/or the registered nurse and recorded on an incident form. The resident and/or the designated representative is advised. There is a process for comprehensive analysis of any medication errors, and compliance with this is verified. Medication errors have decreased significantly with the electronic medication system in place.</p> <p>Standing orders are used, are current and comply with guidelines.</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 a head cook and 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. Any recommendation at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration. The certificate is displayed in the dining room. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the food plan. The head cook and staff interviewed had all undertaken a safe food handling qualification and completed all 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 preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment to meet residents' nutritional needs is readily 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. There was sufficient staff on duty in the dining rooms in all service areas at meal times, to ensure appropriate assistance is available to residents as needed.</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 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 a referral for reassessment to the NASC is made by the general practitioner or the acting clinical leader in consultation with the resident and family/whānau. 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>	CI	<p>Information is documented using validated nursing assessment tools such as Abbey Pains Scale, Braden Scale, falls risk, skin integrity, nutritional screening and depression scale and other risk assessment recognised tools. These tools are used as a means to identify deficits and to inform care planning. The sample of PCCPs reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by trained interRAI assessors on site. A falls risk project was developed and implemented when high falls was identified as being a problem in the facility with positive outcomes for the organisation.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Person centred care plans reviewed reflected the support needs of residents, and the outcomes of the integrated process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any changes in care required is documented and verbally passed on to relevant staff. Residents and families interviewed reported participation in the development and ongoing evaluations 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>	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. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified medical input is sought in a timely manner, medical orders are followed, and care is managed effectively and in a caring manner by all staff. Healthcare assistants confirmed that care was provided as outlined in the documentation. A range of equipment and resources was readily available, suited to the level of care provided in each care setting being rest home, hospital or dementia care, 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 by three staff, one of whom is a diversional therapist holding the National Certificate in Diversional Therapy.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities/recreational assessments are regularly reviewed to help formulate an activities calendar that is meaningful to the residents. The residents' activity needs are evaluated six-monthly or more often if required as part of the formal PCCP review.</p> <p>The planned monthly activities calendar sighted and displayed matches the skills, likes, dislikes and interests identified in assessment data reviewed. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group and regular events are offered. Examples include exercise to music, involvement in the community, entertainment, theme days and special events, music, bingo, card games and pet therapy.</p> <p>The activities calendar is discussed at the minuted residents' meeting and indicates residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the activities provided and that information gained is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and fun and wish to participate.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered 24 hours a day at times when residents are most physically active and/or restless. This includes music sessions, entertainment, pet therapy and other activities. The 24 clock assessment in the records reviewed has resulted in reducing the need for medication, improved appetites and improved sleep patterns.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</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 also reported to the registered nurse and/or the acting clinical leader.</p> <p>Formal PCCP evaluations occur every six months in conjunction with the six monthly interRAI reassessments or a residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed for recurrent falls, weight loss and progress evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process. Other plans such as wound and pressure injury management plans were evaluated each time the dressing was checked/changed. Residents and families/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 disability service providers. Although the service has a contracted GP, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' records reviewed including radiology, skin specialist, geriatrician, mental health services for older persons and other health professionals.</p> <p>Referrals are followed up on a regular basis by the registered nurses and/or the GP. The resident and family/whānau are kept well informed of the referral process, as verified by documentation and family 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>Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed this.</p> <p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage.</p> <p>There is provision and availability of personal protective clothing and equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are risks.</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 of warrant of fitness is displayed. There have been no building modifications since the previous audit.</p> <p>The service has a planned and reactive maintenance schedule implemented. Equipment is available, including shower chairs and sensor alarm mats. There is an annual test and tag programme and this is current with checking and calibration of clinical equipment completed annually. Interviews with staff and observation of the facility confirmed there is adequate equipment. The regional maintenance manager and maintenance person were both interviewed.</p> <p>There are quiet areas throughout the facility, including the dementia unit, for residents and visitors to meet. There are internal courtyards and lawn areas with shade, seating and outdoor tables.</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 toilets/bathing facilities available. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. The dementia care rooms all have en-suite facilities.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own en-suite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</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>There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in hospital rooms needing this, with sufficient space for both the equipment and at least two staff and the resident, for example hoists and wheelchairs. The residents' rooms are personalised with furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</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>The service has lounges, dining rooms and an activities room. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents can access areas for privacy when required. The dining areas have ample space for residents.</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 laundry services are completed at another Oceania site and collected from and returned to Takanini Lodge daily. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the resident rooms. The linen trolleys are clearly labelled to identify resident's individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard for chemical storage and are aware that their trolleys must be with them at all times.</p>

		<p>Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products 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>The service has an evacuation plan, approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations guides their practice. Fire drills are completed six-monthly. The orientation programme includes fire and security training. Checking the fire exits daily for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas barbeques. The service uses an escalating electronic call bell system that can escalate to the general manager, if not answered. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways, dining rooms. Call bell audits are routinely completed and residents and family state there are prompt responses to call bells.</p> <p>External doors leading to the gardens and outside doors are locked after sunset, these doors can only be opened from the inside. Staff complete a security check of all outside doors in the evening that confirms that security measures are in place. The local police complete two security checks per day and there is also a security camera in place at the back door of the facility.</p> <p>There has been an incident where a vehicle crashed into the electrical pole which provides power to the electrical boards in the facility. This caused the power boards in the facility to blow up and burn. The fire was managed appropriately and authorities were informed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>In the dementia unit heating is provided through heat-pumps. In the hospital heating is provided through panel heaters in each resident's room with heat-pumps in communal areas. There are designated external areas for residents to smoke. Families interviewed confirmed the facility is maintained at an appropriate 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 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 programme. Infection control management is guided by a comprehensive suite of current infection control policies and procedures, developed at organisational level. The infection prevention and control programme and manual are reviewed annually.</p> <p>The acting clinical leader is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection prevention and control matters, including surveillance results, are reported monthly to the business and care manager and tabled at the quality/risk meeting. This committee includes the business and care manager, the infection prevention and control coordinator and the quality care manager, the health and safety officer and representatives from all service areas.</p> <p>The infection prevention and control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related 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, and has been in this role for only a few months. The infection prevention and control coordinator completed training in March 2017 on infection prevention and control through the DHB online education programme. This was verified in the training records reviewed. Well established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The general practitioner is also available for advice. The infection prevention and control 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. There have been no outbreaks of infection since the last audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</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. Policies were last reviewed 2016 and include appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitizers, good hand washing techniques and use of disposable aprons, gloves, as appropriate to the care setting. Hand washing and sanitizer dispensers are readily available around the facility. Staff interviewed verified knowledge of infection</p>

<p>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>Priorities for staff education are outlined in the infection prevention and control programme annual plan. Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses and the infection prevention and control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an outbreak or an increase of infection incidence has occurred, there is evidence that additional staff education has been provided in response. Barrier nursing is provided as required.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about hand washing, advice about remaining in their rooms if they are unwell, increasing fluid intake during the day as much as possible.</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 aged care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies or other skin infections. When an infection is identified, a record of this is documented on the infection reporting form. The infection prevention and control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of surveillance 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. This is reported to the quality care manager and the business care manager. Data is benchmarked externally within the organisations other aged care providers. Benchmarking has provided reassurance that infection rates in the facility are below average for the sector.</p> <p>Any new infections and any required management plans are discussed at handover to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in the meeting minutes sighted and interviews with staff.</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>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 is the acting clinical leader who is responsible for oversight for enabler and restraint management in the facility and demonstrated a sound knowledge of the organisation's policies, procedures and practice and their role.</p> <p>On the day of the audit, eight residents were using restraints and no residents were using enablers. Enablers when in use are the least restrictive and used voluntarily at a resident's request. Processes ensure the ongoing safety and wellbeing of the resident is maintained.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and records reviewed of those residents who have approved restraints and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the acting clinical leader and the general practitioner, are responsible for the approval of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of residents' records and interview with the coordinator that there are clear lines of accountability. It was also noted that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/enduring power of attorney (EPOA) involvement in the decision making, as is required by the organisation's policies and procedure, was on file in each case. Use of a restraint or an enabler is included in the PCCP.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the standard. The initial assessment is undertaken by the registered nurse with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The acting clinical leader/restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner interviewed confirmed involvement in the final decision on the safety of the use of restraint. The assessment process identified the underlying aetiology, history of restraint use, cultural consideration, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator described the alternatives to restraints are discussed with staff and family/whānau members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as using low beds, sensor mats and other de-escalation techniques before use of restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records contain the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's PCCP and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed understand the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records evidenced the individual use of restraints is reviewed and evaluated during the PCCP and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the general practitioner, staff and families. 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 the acting clinical leader and the quality care manager confirmed that the use of restraint is minimised.</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.

No data to display

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 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as</p>	CI	<p>The residents' individual records reviewed evidenced all routine assessments and interRAI assessments have been completed. In response to resident assessments and the number of falls reported in the incident management outcomes, it was identified that high falls was a significant problem in the facility. A baseline for a research project was established when initial investigations evidenced that they had an average of 45 falls per month in 2011.</p> <p>A project was implemented over periods of 12 months, June to June. Actions taken included all residents at risk of falling were provided with hip protectors and 'high-low' beds. All residents had a full physiotherapist assessment to identify any contributing factors to their falls, as well as an overview of their physical abilities relating to mobility. All residents at risk of falls were commenced on Vitamin D therapy. In addition the service providers completed falls risk analysis on each high risk resident</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis of the falls risk prevention programme over and above what is already in place at this facility. Reviews of this project occurred annually including analysis of all data, trending and reporting to support office, staff and residents. The evidence of actions taken was reflected in the services annual reduction of falls 2013-2014 falls reduced by 53%, 2014-2015 reduced by 16%, 2015-2016 by 33% and 2016-2017 current period to date by 9.1%. The success of this project is evident in the outcomes expressed in percentages in which falls have been reduced in the facility. The service implemented this project over and above the Oceania processes to prevent falls. This project has improved the service provision and safety management of those residents at</p>

<p>the basis for service delivery planning.</p>		<p>regarding times of day they were falling and the days of the week were considered. Staff received training in relation to 'intentional rounding'. The PCCPs were updated with additional times for checking the individual residents concerned. The staff break times were reviewed to ensure there was adequate cover on the floor at all times. Possible correlation of residents having an infection, were receiving wound care and/or had significant weight loss were reviewed closely. The information was collated by the business and care manager.</p>	<p>risk of falling.</p>
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End of the report.