

Sound Care Limited - Eltham Care Rest Home

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:	Sound Care Limited
Premises audited:	Eltham Care Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 13 November 2017 End date: 14 November 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:	28

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

Eltham Care Rest Home provides services for up to 24 rest home and 17 secure dementia care residents. The service is owned and operated privately. The owner/director works as the facility manager. She is a registered nurse with a current practising certificate. She is supported by a clinical registered nurse and a kitchen manager. Residents and families 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, a mental health nurse and the general practitioner.

This audit has resulted in a continuous improvement rating in medication management. No areas were identified for improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

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

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

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

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.		Standards applicable to this service fully attained.
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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 owner/manager is regular and effective. The management team are experienced and suitably qualified for the roles they undertake.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. 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. Up to date, legible and relevant residents' records are maintained using an integrated hard copy file.

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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The organisation works closely with the local Needs Assessment and Service Co-ordination 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. Shift handovers and communication sheets guide continuity of care.

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' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and

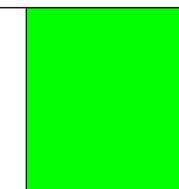
involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two diversional therapists and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and were 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. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified a high level of 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 was 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 by staff ensuring the facility is secured after dark.

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. One enabler was use at the time of audit. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. 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, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. 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, data is analysed, trended, benchmarked and results 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	0	45	0	0	0	0	0
Criteria	1	92	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>Eltham Care Rest Home 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.</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 interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents in the secure unit had EPOAs in place.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents and/or their family member, are given a copy of the Code, which also includes information on the Advocacy Service. Pamphlets regarding the Advocacy Service were accessible and available at the front entrance. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families 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>	FA	<p>The complaints/concerns 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. Residents and family members confirmed during interview that they are aware of where complaints forms are located throughout the facility.</p> <p>The complaints register reviewed showed that one complaint had been received since the previous audit. This complaint was made to the Taranaki District Health Board with multiple issues raised. This occurred on the 06 October 2017 and the TDHB investigated on the 09 October and found that all issues were unsubstantiated. Documentation shows that actions taken to investigate the complaint, by the facility, were completed within the timeframes. No corrective actions were required. The owner/director confirmed that if a corrective action is required, follow up and improvements would be made where possible.</p> <p>The owner/director 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 Health and Disability Commission.</p>
<p>Standard 1.1.2: Consumer Rights During Service</p>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in both English and Maori, in common areas together with information on</p>

<p>Delivery</p> <p>Consumers are informed of their rights.</p>		<p>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 respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information was held securely and privately, exchanging verbal information, administering medications and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is one resident in Eltham Care Rest Home at the time of audit who identifies as Māori. Evidence verifies staff support the resident 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 the local Maori health care providers. The resident is enabled to continue to speak te reo Maori by visiting colleagues who reside at other facilities and being actively involved in marae issues.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met,</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>and this supported 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 members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. The registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals (for example, hospice/palliative care team, gerontology nurse specialist, speech language therapist, community dietician, services for older people, and mental health services for older persons), and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to access external education through the District Health Board (DHB) and on line training forums. The clinical RN participates in the DHB's professional development recognition programme.</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls, improvement in the quality of meals provided, implementation of an electronic medication management system to reduce risk of medication errors, a commitment to enabling residents to participate in community events and activities, and the high number of highly qualified care staff employed at Eltham Care Rest Home.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their own or 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 reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Interpreting New Zealand or the DHB when required. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<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 quarterly reports to the owner/director showed adequate information to monitor performance is reported including complaints, compliments, quality improvement outcomes, quality data results and emerging risks and issues. The owner/director works at the facility as the facility manager and attends all staff meetings, so is fully aware of what is occurring on a daily basis.</p> <p>The service is managed by the owner/director who is a register nurse. She is assisted by a registered nurse who manages clinical issues on a day to day basis (clinical nurse), and the kitchen manager. All three managers hold relevant qualifications appropriate to the roles they undertake. The clinical nurse was appointed seven months ago and is experienced in aged care. The owner/director is experienced in aged care management and purchased the facility nine months ago. The kitchen manager who works as the cook has a tertiary qualification in hotel and restaurant management and a diploma in professional cookery. He commenced the same time as the owner/director. Responsibilities and accountabilities were defined in job descriptions and individual employment agreements sighted. The owner/director and clinical nurse confirmed their knowledge of the sector, regulatory and reporting requirements. The clinical nurse maintains currency through ongoing on-site and of-site education and ensures all New Zealand Nursing Council requirements are met via Taranaki District Health Board's (TDHB) Professional Development and Recognition Programme. The owner/manager attends clinical and management education, seminars and training. She is an approved assessor for the Careerforce aged care programme. Both RNs are interRAI competent.</p> <p>At the time of audit, the service holds contracts with Taranaki DHB for Long Term Support of Chronic Conditions for which one resident receives services, the Age Related Residential Care for which 25 residents were receiving services, consisting of nine dementia care residents and 16 rest home level care residents. There are three boarders who receive assistance with cares and are awaiting re-assessment from the assessment service to review their level of care.</p> <p>One boarder is not included in the number of beds occupied as they receive hotel services only. The service also holds a Residential Respite Service contract with the TDHB for day care and this contract is not included</p>

		in this 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 owner/manager is absent, the clinical nurse, the kitchen manager, and the senior diversional therapist carry out all the required duties under delegated authority. During absences of the clinical nurse, the role is undertaken by the owner/director and a casual RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise.</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, wound care, pressure injury management and internal audits. Monthly reviews are undertaken for all quality data and quarterly benchmarking against previously collected data is graphed and shared with staff. This includes incidents and accidents, complaints, infection control, and health and safety. Restraint is not benchmarked as there has only been one enabler in use since 2013.</p> <p>There is a set agenda for meeting minutes and review confirmed regular analysis of quality indicators and that related information is reported and discussed at the management team meetings, and at staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. One example related to cleaning services. Corrective actions put in place show that following a review of cleaning hours the roster was changed so that the cleaner now works Monday to Thursday and then Saturday. Caregivers do the cleaning on Friday and Sunday. Refer to finding in medication management (1.3.12) related to quality improvements made to this area.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (September 2017) showed that residents and relatives are very happy with current services. During interview, one family member stated that the level of cleaning is greatly improved and all interviews with family and residents confirmed the present owner/director has made positive changes to the environment. This was supported by staff who stated they now feel like a team and are proud of the facility they work in.</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 developed by an</p>

		<p>off-site provider, based on best practice and were current. They are personalised for Eltham Care Rest Home. All policies and procedures sighted are up to date. 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 owner/director described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The owner/director and the clinical nurse are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	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 at management meetings and all issues are discussed at staff meetings as confirmed in meeting minutes sighted and during staff interviews. One initiative for improvement occurred when the number of resident falls increased. This included detailing time of falls and possible causes. The use of the CCTV camera footage showed any falls which occurred in common areas and the owner/director, clinical nurse and GP reviewed this for the falls recorded. Actions put in place resulted in a reduction in fall numbers over a three month period. The GP confirmed during interview that the use of CCTV footage was of great assistance when reviewing falls which occurred in common areas, especially in the dementia unit where many residents cannot explain what had happened. Another corrective action which is well documented relates to the follow up of medication errors; this has resulted in a change from weekly packs to 28 day packs. (Refer comments in 1.3.12). Since the packs were introduced in June 2017 there has only been one medication error.</p> <p>The owner/director described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification made to the Ministry of Health (Section 31) related to an increased number of residents who developed lower respiratory tract infections in September 2017.</p> <p>No other significant events have occurred since the previous audit. For example, no police investigations, coroner's inquests or issues based audits. (Refer to section 1.1.13 related to DHB follow up of a complaint which was unsubstantiated).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</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. During interview the cleaner stated she is enrolled to commence her training.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</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 and a performance review after a three-month period, at six months and then annually.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. At the time of audit, there are eight level four staff, six level three, three level two and two recently employed staff (one caregiver who works in the rest home and the cleaner) who have yet to complete NZQA qualifications to meet the requirements of the provider's agreement with the DHB. The owner/director is the internal assessor for the programme. Staff working in the dementia care area have all completed the required dementia specific education. There are two RNs, plus a RN employed on a casual basis, trained and 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>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>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. 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. The on-call is shared between the owner/director and the clinical nurse. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of four weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff, including non-clinical staff, hold current first aid certificates. There are dedicated staff for the dementia care unit on all shifts.</p> <p>The kitchen is staffed by a cook between the hours of 7am to 3pm, a kitchen hand works 9am-1pm and a tea cook 4pm to 6pm seven days a week. Dedicated cleaning staff work five days a week 9am to 2.30pm. The administrator works Monday to Friday 8am to 12 midday.</p> <p>There are two activities staff, one in the dementia care unit who also undertakes caregiving duties and one in the rest home who works 0800-1630 Monday to Friday. The clinical nurse works Monday to Friday 0900-1700. The owner/director is rostered Monday to Friday but as she lives on site she stated that she is usually available in the weekends.</p> <p>An improvement has been made to shift handover times, an additional 15 minutes has been added to each shift to all more time to discuss every resident and a documented handover sheet has been introduced. Staff report this is working very well. ‘</p>
<p>Standard 1.2.9: Consumer</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique</p>

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site however it is difficult to identify the system that has previously been used. Present records 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. All residents in the secure unit have evidence verifying placement in the unit is required. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical registered nurse (CRN). They are also provided with written information about the service and the admission process.</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 reviewed contained completed demographic detail, assessments 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>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Taranaki District Health Board's (TDHB) 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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</p>	FA	<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. 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.</p>

<p>and safe practice guidelines.</p>		<p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications 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. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed 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 review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit, however appropriate processes are in place to ensure this is managed in a safe manner if residents request a desire to self-administer in the future. A resident who had previously self-administered is now receiving medications administered by staff as required.</p> <p>Medication errors are reported to the CRN and FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. A quality initiative implemented to minimise the number of medication errors is an initiative recognised as providing continuous improvement in medication management at Eltham Care Rest Home</p> <p>Standing orders are not used.</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 qualified chef in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian this month (16 October 2017). Recommendations made 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. Fridge, freezer and chiller temperatures in all areas are monitored and are within the required range. Food in the fridges is dated to indicate use by dates, as are decanted items in the pantry. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. A cleaning schedule was sighted and compliance with the schedule verified.</p> <p>The cook is a qualified chef and 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>An initiative to address residents' dissatisfaction with the food and the appearance of the meals was initiated in February 2017. The focus was on improving food quality, taste and appearance. Evidence of residents greatly improved satisfaction with meals was verified through resident and family interviews, satisfaction surveys, resident meeting minutes and residents' weight records. In addition to this, the opportunity for a cooked breakfast of eggs, bacon etc. has been made available to residents on a daily basis. Any areas of nutritional dissatisfaction are promptly responded to.</p> <p>Residents in the secure unit have their nutritional needs met as verified by documentation, observation and interviews and have access to food any time over the twenty four hour period.</p> <p>Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms 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>	<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. Examples of this occurring were discussed with the FM. 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 completed by one of three trained interRAI assessors on site.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Residents in the secure unit have behaviour management plans that are inclusive of triggers and the required interventions to manage behaviours, including documentation and assessment following medication changes.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families 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, and includes cultural, sexual and behavioural needs. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. 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 by two trained diversional therapists.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The residents from the secure unit have an activities plan in place that incorporates a holistic approach over twenty four hours. Activities are provided in the unit, however residents are able to participate in the rest home activities and outings if they are suitable to the resident's needs.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included ten pin bowling in New Plymouth, access to the facility's Karaoke machine to sing the old favourites, visiting entertainers, quiz sessions, frequent outings to join in community events or participate in local club activities, weekend church services and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys</p>

		demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme very enjoyable.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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 in conjunction with the six-monthly interRAI reassessment or as 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. Examples of short term care plans were consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound / skin tear management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, 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 older persons' mental health services, dental services, and dietician services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff training has been completed related to safe chemical handling. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide ongoing 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. There is provision and availability of protective clothing and equipment and staff were observed using this.

substances, generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 01 May 2018) is 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 (21 March 2017) and calibration of bio medical equipment (March 2017) is current as confirmed in documentation reviewed, interviews with staff and observation of the environment. The environment was hazard free, residents were kept safe and independence was promoted. There is a preventative maintenance schedule which is signed off by the owner/director when each task is complete.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The dementia unit outdoor area is secure and has easy ramp access from the lounge area.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required; any requests are appropriately actioned. This was confirmed in documentation sighted. Residents and family interviews confirmed they are happy with the environment. They are very happy with the improvements made by the new owner and this includes having the gardens upgraded which now allows all common areas to have views of the countryside.</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 one bedroom with a toilet ensuite and staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>A recent upgrade to hand towel dispensers has left screw holes exposed. This was being actioned at the time of audit and is clearly identified in the maintenance book.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</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</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas in the rest home and the dementia care area 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>As observed during the audit, residents from the dementia area join the residents from the rest home area for some activities and entertainment.</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>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry which is well equipped and has a good dirty to clean flow. Care staff and dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family interviewed reported the laundry is managed well and their clothes are returned in a timely manner. This is supported by the results of the satisfaction survey which showed that there has been an improvement in laundry and cleaning over the past few months.</p> <p>The cleaner/laundry person has received appropriate training. 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 chemical usage is monitored by the off-site provider. The facility has undertaken a quality improvement project related to cleaning and laundry which identifies staff involvement in the decision to change suppliers. The laundry and cleaning review resulted from the June internal audit results. Following the corrective actions being completed the re-audit gained a 100% pass rate. Staff confirmed during interview that the updated training received is more in-depth and that there has been an improvement in the visual cleanliness of laundry and that the newly purchased cleaning equipment (vacuum cleaner and colour coded buckets) makes cleaning easier.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 30 June 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 March 2017, and documentation identifies the next fire evacuation is to occur again on 20 November 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 BBQ's were sighted and meet the requirements for the 41 residents. Water storage tanks are located at the rear of the complex. 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 by staff. Staff and residents confirmed they feel safe at the facility at all times. The owner/director has recently installed CCTV cameras in common areas which she monitors in her office and can also view from her lap top. Prior to installing the cameras, staff, residents and families were informed. There are notices around the facility stating the cameras are in use.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by electric wall mounted heaters in residents' rooms and in the communal 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</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CRN. The infection control programme and manual are reviewed annually.</p> <p>The CRN, with input from the FM, is the designated infection control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to</p>

<p>visitors. This shall be appropriate to the size and scope of the service.</p>		<p>the FM and tabled at the quality/staff meeting. Infection control statistics are collated in the organisation's database and analysed against previous records. There is an IPC committee which meets three monthly to discuss any infection control matters, and includes staff from kitchen, laundry/cleaning, a healthcare assistant from each of the two areas, and the IC nurse</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 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 control nurse (ICN) has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken infection prevention and control (IPC) training by attendance at DHB study days, and completion of on line training in IPC, as verified in training records sighted. Well-established local networks with the gerontology nurse specialist and the infection control team at the DHB are available for expert advice if additional support/information is required. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICN 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 control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standards and current accepted good practice. Policies were reviewed within the last year (March 2017) and included appropriate referencing.</p> <p>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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in lower respiratory tract infections.</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</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term 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. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and FM review all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>An IC report was sent to the Ministry of Health (MOH) in September 2017 notifying them of an outbreak of lower respiratory tract infections at Eltham Care Rest Home. Evidence verified this was managed in line with best practice guidelines.</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. Policy states that enablers are voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining resident independence and safety. The restraint coordinator (clinical nurse), 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>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members such as the use of sensor mats, low beds and</p>

		<p>distraction methods used for the management of challenging behaviour.</p> <p>On the day of audit, no residents were using restraints. One resident was using bedside rail enablers. The resident has signed a consent for the use of the enabler and documentation identifies this is reviewed six monthly. The resident wishes to continue with the bedside rails as they make them feel secure when in bed.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. This was confirmed during staff interviews.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	CI	<p>In December 2016, a risk related to medication management was identified with seventeen medication errors being recorded that year. Analysis identified subsequent risks associated with hand written medication charts, and medications frequently requiring to be changed by the GP, who was not on site. The frequent changes and faxing of updated drug charts made charts difficult to read. There was a potential for medication errors in dispensing and administration related to several versions of a medication chart being in existence and charts being illegible with numerous changes being made. In addition, medication charts were frequently not signed when the medication was given, medications were not checked against the medication chart and the wrong dose and the wrong medication being administered was a factor in medication errors.</p> <p>The decision was made to explore the option of using an electronic medication management system with the aim of:</p> <p>1) Minimising the potential for medication errors by ensuring each resident’s medication chart is current, contains only current medications</p>	<p>A quality initiative was developed in December 2016 in response to an identified potential risk to residents related to the use of hand written medication charts.</p> <p>Following the implementation of this initiative, there has been a considerable reduction in medication errors and more efficient and effective use of medication charts which is subsequently improving care to the residents. GPs are now able to quickly and easily update medication charts.</p>

		<p>and is legible.</p> <p>2) Increasing the opportunity for GPs to quickly and easily update medication charts.</p> <p>3) Enabling only one medication chart to be active.</p> <p>4) Enabling a user-friendly system that provided alerts to care staff when the correct process was not being complied with.</p> <p>The chosen system was implemented in January 2017.</p> <p>Since the implementation of the system there were seven errors March to June 2017. Six of these were with medications being found on the floor, and one around an incorrect dose being given. There have been no medication errors since June 2017. A review in October 2017 verified all the aims of the project had been achieved. Each resident's medication chart is current, contains only current medications and is legible. GPs are able to quickly and easily update medication charts. Only one medication chart per resident is active and medication errors have been minimised.</p>	
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End of the report.