

# Ashwood Park Lifecare (2012) Limited - Ashwood Park Retirement Village

---

## Introduction

This report records the results of a Surveillance 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 Health and Disability Auditing New Zealand 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:

<b>Legal entity:</b>	Ashwood Park Lifecare (2012) Limited
<b>Premises audited:</b>	Ashwood Park Retirement Village
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 22 November 2017      End date: 23 November 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	127

# 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

Ashwood Park is part of the Arvida Group and provides cares for up to 121 residents requiring rest home, dementia or hospital (medical and geriatric) level care and up to a further 35 residents requiring rest home level care in serviced apartments. On the day of the audit there were 127 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service is managed by two village managers who previously owned the facility. The managers are well qualified and experienced for the role and are supported by a facility nurse manager, a clinical manager in each of the units and a quality manager/education coordinator. Residents, relatives and the general practitioner interviewed spoke positively about the service provided.

The service has addressed all three shortfalls from their previous certification audit relating to notifying families of incidents, wound documentation and restraint monitoring. This audit identified one shortfall around documented interventions.

## 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.
--	--	--

Residents and family are well informed including of changes in residents' health. The village managers and facility nurse manager have an open-door policy. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints are shared with staff.

## 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.
---	--	--

Ashwood Park has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. Aspects of quality information are reported across the two monthly combined staff and monthly quality meetings. There is an annual internal audit calendar schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at bi-monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme is being implemented with a current training plan in place for 2017. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
---	--	--

The registered nurses assess, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner, nurse practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. The registered nurses and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies.


The medicine charts reviewed on the electronic medication system met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner. The lead diversional therapist oversees the activity team and programme for each unit ensuring that activities meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. The programme includes community visitors, entertainers and outings. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site by an external company. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritious snacks are available 24 hours.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
---	--	---

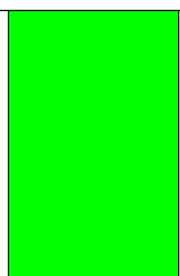
Ashwood Park has a current building warrant of fitness.

## 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.
---	---	--

Ashwood Park has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit there were four residents using enablers and ten residents requiring restraints. The clinical manager for the hospital unit is the designated restraint coordinator.

## 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.
---	--	--

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control coordinator (facility nurse manager) is responsible for the collation of surveillance data. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Documentation sighted for two outbreaks evidence these were well managed.

## 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)
<b>Standards</b>	0	17	0	1	0	0	0
<b>Criteria</b>	0	40	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. There is a complaint's form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. There is a complaint's register to track progress for follow-up and sign off in appropriate timeframes. Verbal and written complaints are documented. Twenty complaints have been received since the last audit. Nine complaints have been received in 2017 year-to-date. All complaints reviewed had noted investigation, timeframes and corrective actions when and where required, resolutions were in place. Results are fed back to complainants. All staff interviewed were able to describe the process around reporting complaints. One recent complaint made through the Health and Disability Commissioner (HDC) in 2017 is ongoing and is currently still being investigated.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents (five hospital, three dementia care and two rest home) forms reviewed for October and November 2017 had</p>



		documented evidence of family notification or noted if family did not wish to be informed. The previous finding around notifying families of incidents has been addressed. Six relatives (one rest home, three hospital and two dementia) interviewed confirmed that they are notified of any changes in their family member's health status. Five residents (rest home) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ashwood Park lifecare is part of the Arvida Group. The service provides dementia, rest home and hospital (medical and geriatric) level care for up to 121 residents and rest home level care for up to a further 35 residents in studio apartments. On the day of the audit there were 127 residents including 45 of 48 hospital level residents including, one resident on respite care and three on YPD contracts, 42 of 47 rest home residents, including one resident on respite care and one on a 'younger persons with disabilities' (YPD) contract, and 26 residents in the 26-bed dementia unit. There were 14 rest home residents in the 35 studio apartments. All other residents were admitted under the aged residential related care (ARRC) agreement.</p> <p>There are two village managers (husband and wife). One village manager looks after the operational and financial management and the other village manager covers the HR management, property and maintenance requirements. The village managers have previously managed aged care facilities for ten years and owned Ashwood Park prior to the purchase by the Arvida Group in 2014. The village managers are supported by a facility nurse manager. The facility nurse manager has been at the service for two years, having previously held leadership and management positions. She is supported by a unit clinical manager in each of the three units, all of who are qualified and experienced for the roles. Additionally, the management includes a quality manager/education coordinator.</p> <p>The village managers' report to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Ashwood Park has a business plan for 1 April 2017 to 31 March 2018 and a quality and risk management programme.</p> <p>The village managers have completed in excess of eight hours of professional development in the past twelve months.</p>
Standard 1.2.3: Quality And Risk Management	FA	There is a business/strategic plan that includes quality goals and risk management plans for Ashwood Park. Interviews with staff confirmed that there is discussion

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>about quality data at various staff meetings. The service has created a staff magazine with the aim of improving staff communication and focusing on quality improvement. One of the village managers advised that she is responsible for providing oversight of the quality programme on-site, which is also monitored at an organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site-specific service's policies are being transitioned over to the Arvida Group policies, which continue to be reviewed at least every 2 years across the group. Head office provides new/updated policies via the intranet. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use (when used) is reported within the quality and clinical staff meetings. There is an annual internal audit calendar in place.</p> <p>All staff interviewed could describe the quality programme corrective action process. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. The health and safety committee has been recently changed to have more representative membership, representatives have received training in their role. Hazard identification forms and a hazard register are in place. There is an annual staff training programme that is implemented and based around policies and procedures and records of staff attendances maintained. Infection control programme is implemented, and all infections are documented monthly. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2017 resident relative survey overall result shows satisfaction with services provided. Resident/family meetings occur every four months and resident and families interviewed confirmed this. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The facility nurse manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Ten incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls. Discussions with the village managers</p>

		confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Four section 31 incident notification forms (sighted) have been completed since the last audit. There was one notification for a police investigation (missing person) in September 2017, one for a pressure injury in August 2017, one for a dementia resident wandering in November 2016 and one for a coroner's inquest in June 2017.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place, which include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed, including; one facility nurse manager, one quality manager/education coordinator, two, unit clinical managers, one lead diversional therapist, two healthcare assistants (HCA) and one registered nurse (RN). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all of the eight staff files reviewed. Completed orientation is on files and staff described the orientation programme. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2016 has been completed and the 2017 programme is being implemented. Education/training has been provided on the mandatory education/training topics and records are per the scheduled calendar. The training schedule includes a monthly study day on mandatory education, (e.g., code of rights, cultural awareness and abuse and neglect). The facility nurse manager, unit clinical managers and RNs are able to attend external training, including sessions provided by the local DHB. Discussions with the HCAs and the RNs confirmed that ongoing training is encouraged and supported by the service. There are 13 RNs and 11 have completed interRAI training.</p> <p>There are fourteen HCAs who work routinely in the dementia unit and nine have completed the dementia standards. Three are in process of completing and the remaining two have just commenced working in this unit, so are have not begun their studies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Ashwood Park policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 132 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village managers and facility nurse manager work 40 hours per week, Monday to Friday and are available on call after</p>

		<p>hours. In addition, there are three-unit clinical managers. There is at least one RN on at any one time. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents.</p> <p>The service currently has 45 of 48 hospital residents, 42 of 47 rest home residents, 26 of 26 dementia care residents and 14 rest home residents in the 35 studio apartments.</p> <p>In the hospital unit there are two RNs on the morning and afternoon shifts and one RN on night duty. The hospital RNs are supported by nine HCAs rostered on the morning, seven HCAs on the afternoon shift and three HCAs on night duty.</p> <p>In the rest home unit, there is one RN on the morning and afternoon shifts. The rest home RNs are supported by seven HCAs rostered on the morning, four HCAs on the afternoon shift and two HCAs on night duty.</p> <p>In the dementia care unit, there are four HCAs rostered on the morning and afternoon shifts, and one HCA on night duty.</p> <p>The studio apartments have 14 rest home residents and has a separate roster with one HCA on the morning and afternoon shifts. The HCA in the rest home supervises the rest home level care residents in the studio apartments on the night shift.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs and senior HCAs) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses have completed syringe driver training. All medication is checked on delivery against the medication chart and this is evidenced on the electronic medication system. All medications are stored safely. Medication fridges are monitored daily and maintained within the acceptable temperature range. All eye drops were dated on opening. Standing orders are not used. There were four residents (one rest home and three hospital level of care) self-medicating inhalers/GTN sprays on the day of audit. Self-medication competencies had been completed and reviewed.</p> <p>Sixteen medication charts reviewed on the electronic medication system met legislative requirements. 'As required' medications identified the date and time of administration. Monitoring forms were in place for monitoring the effectiveness of as required analgesia.</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>An external company is contracted to provide all meals. The full-time chef manger is supported by catering assistants. Food services staff have attended food safety training. The four-week seasonal menu has been reviewed by the company dietitian. Cultural preferences and special diets are met. Resident dislikes are known and accommodated. The chef receives a resident dietary profile for new and respite care residents and is notified of any dietary changes. Special diets including modified foods are accommodated. Food is transported in hot boxes and served from bain maries in the units. Nutritious snacks were available 24 hours in the dementia care unit.</p> <p>Fridge and freezer temperatures are taken and recorded twice daily. End cooked food temperatures and serving temperatures are recorded twice daily. Perishable foods sighted in the fridges/chiller were dated. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>PA Low</p>	<p>Eight resident files reviewed (three rest home including one resident in the studio apartments and one resident under 65 years of age, three hospital files including one resident for respite care and one resident under 65 years of age and two dementia care residents. The service is currently transitioning from paper-based to an electronic system. Care plans reviewed overall included interventions to support current needs; however, shortfalls were identified around aspects of implemented care not included in 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>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in each resident file that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Not all interventions had been documented for all assessed needs.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment, treatment and evaluation forms were sighted on the electronic resident information system. The frequency of</p>

		<p>wound reviews is documented at each dressing change and is linked to the work log for that day. The previous finding around frequency of wound reviews has been addressed. There were eight facility acquired pressure injures (five stage one and three stage two) for three residents at hospital level and one at rest home level of care. A RN has the role of wound nurse and there is access to a wound nurse specialist.</p> <p>Changes to resident's health are monitored and identified through ongoing daily assessments. Changes to health are reported to the RN who informs the GP or other allied health specialists. Monitoring forms are used as applicable and are available on the electronic resident information system. Monitoring forms are used for weight, vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 service employs a fulltime qualified and registered lead diversional therapist (DT) who oversees the activity team of two registered DTs and three qualified DTs.</p> <p>The activity team coordinate and implement a six-day week programme Monday to Saturday. The DT (in training) has a current first aid certificate.</p> <p>There are separate activity programmes for each unit (rest home, hospital and dementia care). The residents in studio apartments have the choice of attending studio apartment activities or rest home activities. The programme for the rest home, hospital and studios is Monday to Friday from 9.30 am to 3.00 pm (rest home) and 4.00 pm (hospital). A volunteer is involved six hours a week and assists in providing activities. A seven-day week programme is provided by qualified DTs in the dementia care unit from 10.30 am to 5.30 pm. One of the part-time DT team is shared between the units spending one-on-one time with residents such a beauty time, reading and assist feeds. All programmes are flexible to meet the needs/preferences of the residents. All residents (including dementia care residents under supervision) have the opportunity to attend activities in other units and some activities such as entertainers, housie and church services are combined. Other activities provided include (but not limited to): newspaper reading, get fit exercises, walks, mini golf, housie, colour therapy, crafts, gardening, happy hour, sing-a-longs, baking, men's group and knitting group. Festive occasions and theme days are</p>

		<p>celebrated.</p> <p>Residents under 65 years of age have daily plans that include activities and additional contact with groups outside in the community, including band practices, card groups, stroke club, and lodge meetings. Residents are supported to attend their community groups.</p> <p>There are regular outings for all residents, which include outings for men's group and women with visits to places of interest. The service employs a van driver with a current first aid certificate. Community links include entertainers, RSA visits, pet therapy, shopping and church visitors.</p> <p>A diversional therapy resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The DT is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident and family meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes, for six permanent resident files reviewed. Written evaluations reviewed identified if the resident goals had been met or unmet. Family are invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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>	FA	<p>The service displays a current building warrant of fitness, which expires 1 July 2018.</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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Short-term care plans are used for infections. The infection control coordinator (facility nurse manager) is responsible for the surveillance of all infections and entering data into an on-line data base. This data is monitored and analysed for trends monthly and annually. An infection analysis is displayed on the staff noticeboard and discussed at the infection control committee meetings and quality</p>

		improvement meetings. Benchmarking occurs within the Arvida group. There have been two outbreaks with one in October 2016 (gastroenteritis) and one in January 2017 (sapovirus). Documentation demonstrated the outbreaks were well managed. The relevant authorities were notified.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. During the audit there were four residents using enablers (three hospital level of care and one rest home level of care) and ten hospital level residents requiring restraint (two residents had two restraints). Restraint minimisation is overseen by a restraint coordinator who is the clinical manager of the hospital unit. The clinical manager states that any restraint would be used only when absolutely necessary and as a last resort. Staff education on restraint minimisation and management of challenging behaviour has been provided.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	During the audit there were ten hospital level residents requiring restraint (two residents had two restraints). The three restraint monitoring forms reviewed documented the required two hourly monitoring. The previous finding around restraint monitoring has been addressed.



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	InterRAI assessments were up to date and overall linked to care plans. However, interventions were not all documented for all assessed needs.	Interventions had not been documented in the care plan for; a) pain management for two rest home residents, b) one rest home resident with potential behaviours as identified in the interRAI assessment, c) the management for a stage two pressure injury for one hospital level of care resident, and d) two hospital residents did not have the risks associated with restraint documented in the care plan. Interviews with staff, residents and relatives and tracer methodology identified that care was being provided to meet the needs of the residents in relation to pain management, pressure injury care, de-escalation and restraint minimisation that this criterion has been assessed as low risk.	<p>Ensure interventions are documented to reflect the resident's current needs</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.