

# Elmswood Court Lifecare Limited - Elmswood Retirement Village

---

## 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 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>	Elmswood Court Lifecare Limited	
<b>Premises audited:</b>	Elmswood Retirement Village	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 29 January 2018	End date: 30 January 2018
<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>	68	

# 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
Yellow	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
Red	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

Elmswood Retirement Village is privately owned and provides rest home and hospital level care for up to 79 residents in the care centre and up to 33 rest home residents in the apartment studio's. On the day of the audit there were 68 residents in the care centre and no rest home residents in the studio apartments.

This certification audit was conducted against 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, relatives, management, staff and the general practitioner.

The owner/managing director has a background in business management and has been in the aged care industry for 10 years. She is supported by an experienced non-clinical facility manager and experienced clinical manager. Residents and family interviewed were very complimentary of the services and care they receive.

The service has been awarded continuous improvement ratings around good practice in relation to falls reduction, infection surveillance and garden activities.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
--	--	---

Elmswood staff provide care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents are encouraged to maintain former links with the community. There are a number of community visitors to the home.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

The quality and risk management plan and quality and risk policies describe Elmswood Retirement Village quality improvement processes. Policies and procedures are maintained by an aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. The health and safety programme meet current legislative requirements. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for

safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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>All standards applicable to this service fully attained with some standards exceeded.</p>
---	--	--

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed on the electronic system demonstrated service integration and were evaluated at least six monthly. Resident paper based and electronic system files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses, enrolled nurse and unit coordinator and senior healthcare assistants are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner.

The activity coordinators provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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.
--	--	--

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All rest home bedrooms have toilet ensuites and all hospital bedrooms have full ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

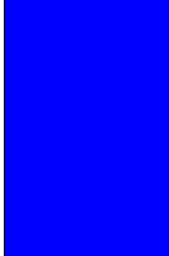
## Restraint minimisation and safe practice

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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. There was one restraint in place on the day of audit. The restraint coordinator is the clinical manager. Restraint

assessment, monitoring and regular evaluations had been completed. Staff receive regular education and training on restraint minimisation.

## Infection prevention and control

<p>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.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
--	---	--

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Responsibility for infection control is the clinical manager. The infection control coordinator has completed on-line training. Staff complete annual training on infection control. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

## 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>	3	47	0	0	0	0	0
<b>Criteria</b>	3	98	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)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families at the front entrance. A policy relating to the Code is implemented and staff interviewed (one clinical manager, three registered nurse (RN), eleven healthcare assistants (HCA) and two activities coordinators) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</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</p>	FA	<p>Informed consent processes were discussed with residents and families on admission. Written general consents, including informed and outings and indemnity forms, were included in the admission process as sighted in nine of nine resident's files reviewed (five rest home including one respite resident and four hospital level of care residents). Caregivers interviewed confirm consent is obtained when delivering cares. Advance directives also identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate.</p> <p>Discussion with family members identifies that the service actively involves them in decisions that affect their</p>

consent.		relative's lives. Admission agreements were sighted for the nine long-term residents and one respite resident.
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Health and Disability advocacy brochures are included in the information provided to new residents and their family during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services. A health and disability advocate is available to residents/family.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the activity coordinators to ensure that the residents continue to participate in their chosen community group including the community centre, blind foundation, community stroke team, workingmen's club and the RSA. Rugby league members visit one resident who is a life member.  There are a number of community visitors to the facility including primary school children, guest speakers, and entertainers.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer (facility manager) leads the investigation of any concerns/complaints in consultation with the clinical manager for clinical concerns/complaints. The general manager is informed of any concerns/complaints. Compliments and complaints are discussed at the bi-monthly staff meeting as sighted in the meeting minutes. Complaints forms are visible throughout the facility. There have been seven complaints in 2017 including two reports to the police and one complaint to the HDC. All complaints have been managed appropriately. Action has been taken within the required timeframes and resolved to the satisfaction of the complainants. The service completed an internal investigation following the HDC report in October 2016. The complaint was resolved October 2017 without any further action. Residents and families interviewed are aware of the complaints process. A compliments and complaints register are maintained on the electronic system.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The facility manager or clinical manager discuss aspects of the Code with residents and their family on admission. Eleven residents (eight rest home and three hospital) and three family members (one rest home and two hospital) interviewed, reported that the

<p>Consumers are informed of their rights.</p>		<p>residents' rights were being upheld by the service.</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>Eleven HCAs interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy, culture, values and beliefs is respected. The residents' personal belongings are respected and not for communal use. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect.</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care for any residents who identify with Māori. There were no residents who identified with Māori on the day of audit. The service has access to a Kaumātua in the community. The staff are also supported by the hospice cultural advisor. Staff receive education on Māori values and beliefs and cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission in consultation with the resident and family. Beliefs and values are incorporated into the residents' care plans as viewed on the resident electronic files. Residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual cultural and spiritual values and beliefs. The service has a link to the Chinese community.</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>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the HCA role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>Good practice around quality care included falls prevention management with a reduction in falls in 2017. There is an RN on duty 24 hours and an RN available on call for additional support as required. Care staff confirmed on interview they feel supported and their contribution into resident care is valued. Policies and procedures reflect best practice and staff are required to read the new/reviewed policies. Residents and family interviewed reported that they are very satisfied with the services received. There are a range of health professionals involved in the residents' care including the general practitioner, physiotherapist and dietitian.</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>There is a policy to guide staff on the process around open disclosure. Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The facility manager and clinical manager operate an open-door policy. Nine incident/accident forms reviewed on the electronic resident files for December 2017 identified family were notified following a resident incident. Family members interviewed confirmed they are notified promptly of any incidents/accidents.</p> <p>Families receive regular village newsletters. Interpreter services are available if required.</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>Elmswood Retirement Village provides care for up to 79 rest home and hospital level residents in the care facility. There are 25 dual-purpose beds. There are 33 studio apartments certified for rest home level of care. On the day of audit there were 45 rest home residents including two respite care and 23 hospital level residents. All other residents were under the ARCC. There were no rest home level of care residents in the studio apartments.</p> <p>Elmswood Retirement Village is privately owned by a company of three directors, one of whom is the general manager across two facilities (Elmswood and Fendalton rest home) owned by the company. Currently there are eight shareholders who meet four times a year and have an annual general meeting. The managing director (general manager) is non-clinical and has been in the aged care industry for 10 years. Clinical governance is provided by a contracted quality/risk consultant/registered nurse.</p>

		<p>Elmswood mission and philosophy is identified in the five-year strategic business plan, which is reviewed annually. The 2016-2017 quality goals were evaluated against progress and achievements documented including implementation of an electronic resident management system and medication system, completion of landscaping (link CI 1.3.7.1), reduction of falls (link CI 1.1.8.1) and improvement training attendance and knowledge. The annual quality goals for 2018 are in the process of being developed.</p> <p>The general manager is supported by a full-time facility manager (previously a psychiatric RN), who is now non-clinical and has been in the role two years. She has a business and management background in the health and disability sector. A clinical manager with aged care experience has been in the role one year and has overall responsibility for clinical operations.</p> <p>The facility manager has attended at least eight hours of education within the last year, related to managing a rest home and hospital including a management study day with an aged care association, attending ARCC forums at the DHB and forums for older persons health and a half study day with psychosocial oncology NZ.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The general manager covers for the facility managers leave. The facility manager at the other facility (Fendalton) is a registered nurse and provides support for the RNs at Elmswood during the clinical manager leave. There are four RNs (including the clinical manager and facility manager (Fendalton) who rotate to provide RN on-call for both facilities.</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 quality and risk management plan and quality and risk policies describe the company's quality improvement processes. Policies and procedures are maintained by an aged care consultant who reviews them to ensure they align with current good practice and meet legislative requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data collected, is analysed and compared monthly and annually for a range of adverse event data. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated.</p> <p>There are monthly infection control/health and restraint meetings. Health and safety committee meetings are also held monthly. Both committees have representatives from each service area. Quality data from all meetings are discussed at the monthly quality/risk meeting which is attended by the general manager, facility managers both sites, clinical manager, diversional therapist and quality/risk consultant. Meeting minutes</p>

		<p>evidence quality data, trends and analysis including areas for improvement around infections, accidents and incidents, health and safety, restraints/enablers, concerns/complaints, internal audit outcomes and quality goals. Benchmarking occurs against NZ industry standards. Information is shared with all staff, as confirmed in meeting minutes and during interviews. Staff receive a monthly newsletter that includes quality data and statistics for infection control and accidents/incidents. Staff meeting minutes are available to all staff on the on-line system.</p> <p>A full facility checklist is completed six monthly that covers the environmental and clinical areas. The quality/risk consultant completes a monthly summary of audits with corrective actions, which are implemented by the relevant person. Additional facility audits are included in the programme such as restraint, infection control, resident files and medication. Corrective actions sighted had been completed and closed out as documented in meeting minutes.</p> <p>Annual resident/relative satisfaction surveys are completed annually in August. All residents and families were very satisfied with the care and services provided in 2017, resulting in 95% satisfaction for rest home and 91% for hospital level residents (April to August 2017). Results from the surveys are collated and fed back to participants through meetings and by newsletter. Any areas of concern are raised as an opportunity for quality improvement.</p> <p>There is a risk management plan in place. The health and safety coordinator (HCA) interviewed, has been in the role eight months and has held the role previously in other employment and has level one of the health and safety training. Committee members from each area of work are nominated onto the committee that meets monthly. Committee meeting minute's evidence discussion on health and safety matters including accidents/incidents and hazard management. A report is forwarded to the quality/risk committee. Staff receive health and safety training during orientation and ongoing. Contractors complete a health and safety induction. A health and safety consultant completes audits and provides updates to health and safety legislation including legislation. The service has a tertiary level of the ACC work safety audit. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. The register is up-to-date.</p> <p>Falls management strategies include wireless sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling (link 1.1.8.1).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident through the resident electronic system. There is documented timely RN assessment for accident/incidents. Incident/accident data is linked to the organisation's quality and risk management programme. Nine accident/incident forms were reviewed. Each incident involved a resident clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for suspected head injuries. The facility manager confirmed their awareness of the responsibility to notify relevant</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>authorities in relation to essential notifications. There has been one coroner case linked to the HDC relative complaint and a police report linked to missing money. There was no further action taken in either case. Both reports had a corresponding section 31 completed.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Ten staff files reviewed (one clinical manager, two RNs, two HCAs, two HCA care lead, one HCA/health and safety, one diversional therapist and one cook) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the clinical manager, RNs and allied health professionals.</p> <p>The service has an orientation programme in place that is currently being reviewed to align with level two of the NZ certificate in health and wellbeing. Healthcare assistants interviewed believed new staff were adequately orientated to the service on employment. The training and education programme covers all the relevant requirements over two years. The service has implemented a programme to increase the level of career force training for the staff. Clinical staff complete competencies relevant to their role, including medication competencies, manual handling and wound care. Four of nine RNs have completed interRAI training.</p> <p>As at 2016 no care staff had completed aged care qualifications. A quality improvement project was implemented in March 2016 to encourage and support care staff to complete Careerforce qualifications. A part-time education officer (non-clinical) who has completed an adult teaching qualification, was appointed to coordinate orientation and education across Elmswood and Fendalton facilities. Education is delivered at the monthly staff meetings, and for those staff unable to attend, a second session is provided, or they are required to read the content. One-on-one teaching is offered for staff requiring assistance. There are several tool box sessions offered for staff as evidenced around clinical indicators including falls prevention and hydration (link CI 1.1.8.1 and CI 3.5.7). The clinical manager is a workplace assessor and the service also contract an external Careerforce assessor. Other education offered is palliative care, delivered by Nurse Maude and has been attended by 19 care staff to date. The physiotherapist trains staff in safe manual handling. Registered nurses have access to the DHB HealthLearn on-line learning modules. As at January 2018 there are 39 care staff at Elmswood of whom 10 commenced with qualifications (over 2016-2017) and 13 of the existing care staff had completed the Careerforce modules. The service has achieved its goal to support care staff to gain Careerforce qualifications</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical manager are full-time Monday to Friday. Residents, relatives and staff</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares.</p> <p>There are 23 hospital level residents in the hospital. On the morning and afternoon shifts in the hospital wing there is one RN, two HCAs on full-shift and two HCAs on short-shifts. On night shift there is an RN and two HCAs.</p> <p>In the rest home there are 45 rest home residents. There is a RN/unit coordinator on mornings, supported by an RN, two days a week to assist with interRAI assessments. On mornings there is one care lead (senior HCA) and one HCA on full duties and two HCAs on short-shifts. There is a second care lead in the studio apartments. On afternoons there a care lead and one HCA on full-shift and two HCAs on short-shift. There is one HCA in the studio apartments. On night shift there is one HCA and one laundry assistant who completes laundry but is also available to assist the HCA.</p> <p>There is the flexibility on the roster to increase hours to meet resident acuity. There is a casual RN and HCAs. When necessary, agency staff are used.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms and electronic records are password protected. Archived records are stored securely. Residents' files demonstrate service integration. Entries are legible, dated, timed and identifiable, including designation.</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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of</p>



<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.</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. The service uses an electronic medication system. Clinical staff who administer medications; RNs, EN and senior healthcare assistants who have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medication is stored safely in the designated medication areas in the rest home and hospital unit. Medication fridges are maintained within the acceptable temperature range. All eye drops and ointments were dated on opening. There were six rest home and two hospital level care residents self-medicating on the day of audit. Self-medication competencies had been reviewed three monthly each resident had secure storage in their room. Standing orders are not used.</p> <p>Eighteen medication charts reviewed (ten rest home and eight hospital level residents) met legislative requirements.</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>All meals at the service are prepared and cooked on-site. The service also provides meals for the facilities sister site, Fendalton Retirement Village. There is a five-weekly winter and summer menu which had been reviewed by a dietitian in November 2017. Meals are prepared in a well-appointed kitchen adjacent to the rest home dining room and served directly to residents from a bain marie. Food is transported to the serviced apartment dining room and hospital dining rooms, placed in the bain marie and served to residents. Kitchen staff were trained in safe food handling, and food safety procedures were adhered to. Staff were observed delivering meals and assisting residents with their lunch time meals as required. Diets were modified as required. Resident dietary profiles and likes and dislikes were known to food services staff and any changes were communicated to the kitchen via the registered nurse. Supplements have been provided to residents with identified weight loss issues. Weights have been monitored monthly or more frequently if required or as directed by a dietitian. Resident meetings and surveys allowed for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicated satisfaction with the food service. Alternatives were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the</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.		referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six monthly or earlier as needed with the interRAI assessment. InterRAI assessments reviewed were completed within 21 days of admission. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused and individualised. Support needs as assessed, were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and sighted in resident electronic files, (e.g., infections and wounds) and have either been resolved, or if ongoing are transferred to the long-term care plan. Long-term care plans evidenced resident and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.  There was evidence of allied healthcare professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian, wound care nurse specialist and older persons mental health services.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP consultation. There is documented evidence in the progress notes of family/whānau contact in each resident file that indicates 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.  Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment and ongoing evaluations were in place for eleven hospital residents with 17 wounds including seven skin tears, two surgical wounds, four basal or squamous cell lesions, two vascular ulcers and two grade-one pressure injuries. In the rest home, 21 wound management plans were in place for 12 residents including 15 skin tears or abrasions, two vascular ulcers and four skin lesions. There

		<p>is evidence of wound nurse specialist involvement in wound management.</p> <p>Continence products are identified in resident files and include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. 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. Monitoring forms are used for weight, vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts.</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>	CI	<p>The service currently employs two activity coordinators who have been in the roles for eight months and one year. The team cover all areas of the facility and work between 54 and 74 hours per week with flexibility to cover the recently vacant full time diversional therapist role. They are supported by a qualified diversional therapist who works at the facilities sister village (Fendalton). The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned on the day were displayed on noticeboards around the facility. Resident files include a personalised activities assessment and plan. The programme is Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents with specific activities for each care level. Hospital residents can choose to attend the rest home or serviced apartment activity programme. Some activities are integrated with the serviced apartments such as entertainment, arts and crafts, exercises and happy hours. The programme has been rejuvenated to include an emphasis on outdoor garden activities, including garden walks, seed propagation and rose naming competition. There are regular outings into the community. The service has a van for regular outings. Activity staff have current first aid certificates.</p> <p>One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. A volunteer visits with a dog weekly. Themes and events are celebrated.</p> <p>A diversional therapy resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The activity team is involved in the six-monthly multi-disciplinary review with the RN. The service receives feedback and suggestions for the programme through two monthly resident meetings and direct feedback from residents and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly for seven of the eight long-term resident files reviewed (four hospital level and three rest home). One rest home resident had not been at the service six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Ongoing nursing evaluations occur as indicated and are documented within the progress</p>

manner.		notes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier. A chemical spills kit is available.</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 on 1 April 2018. The service employs a full-time maintenance manager. He is supported by one full-time and two part-time maintenance/gardeners. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, (e.g., hot water temperature, call bells, resident equipment and safety checks). Medical equipment and electrical appliances have been tested and tagged and calibrated. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. The new hospital unit has ceiling hoists available in every room. There is safe access to the outdoor areas and courtyards on the ground floor. There is a designated outdoor smoking area. Seating and shade is provided.</p>

		Earthquake areas requiring repair were clearly identified and related hazards eliminated or minimised.
<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	All resident rooms in Elmswood are single rooms with hand basin and toilet in each room. Communal showers are available for residents use. There are communal toilets with privacy locks located near the communal areas. All 25 resident rooms in the hospital unit have full toilet and shower ensuite. There are 33 single serviced apartments or studios certified for rest home level care and all had ensuite. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity are maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include vacant/in-use signs.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists in hospital rooms. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large lounge, a large dining room, and small seating areas situated throughout the rest home wings. The rest home dining room is spacious, and located directly off the kitchen/servery area. A second smaller lounge includes a library and internet access for residents and is available for quieter activities and visitors. There is a dining room and lounge in the serviced apartment area. The hospital unit has a large lounge/dining area which opens to the outdoors, and a separate family room. A servery is located adjacent to the dining area.</p> <p>All areas were easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they are able to move around the facility and staff assist them when required. Activities take place in any of the lounges.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry persons and cleaning staff on duty seven nights a week. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry is located in the rest home wing and laundry is transported in covered trolleys to the laundry. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaner's trolley is stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency, disaster policies and procedures are documented for the service. There are emergency flip charts throughout the facility for all emergency disasters. The orientation programme and annual education/training programme include fire, security and emergency/civil defence situations. The fire evacuation scheme has been approved for the rest home and hospital. Fire drills occur every six months, last in August 2017. Staff interviewed confirmed their understanding of emergency procedures. There are adequate supplies available in the event of a civil defence emergency including food, external water tank (1000 litre) and three ceiling tanks (800 litres each), gas cooking and heating. The civil defence kits are checked three monthly. There is emergency power back-up, back-up oxygen cylinders and access to paper-based medication charts. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell within reach. There is at least one staff member on duty 24 hours a day with a current first aid/CPR certificate. The building is secure after-hours.</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>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature with underfloor heating, which can be adjusted to meet individual requirements. The residents and family interviewed confirmed temperatures were comfortable.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>The clinical manager has overall responsibility for infection control across the two facilities. Responsibility for infection control is described in the job descriptions. The infection control coordinator oversees infection control for the rest home/hospital facility at Elmswood and responsible for the collation of infection events. The</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection control programme is reviewed annually by the Elmswood infection control committee who meet monthly.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</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 coordinator has been in the role since March 2017 and held a previous role in infection control. The infection control committee are representative from each service area. The infection control coordinator has completed the on-line DHB health learn infection control module in 2017. There is access to infection control expertise within the DHB, aged care consultant, external infection control specialist, wound nurse specialist, public health, laboratory and microbiologist. The GP monitors the use of antibiotics.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping, incorporate the principles of infection control. The policies have been developed by an aged care consultant and last reviewed September 2017.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete infection control questionnaires. Hand hygiene competencies are completed during orientation and annually.</p> <p>Resident education is expected to occur as part of providing daily care.</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>CI</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly infection control committee meeting and staff meetings. Data and graphs of infection events are available to staff. The service completes monthly, six monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and preventative measures put in place. The service has been successful in reducing urinary tract infections in the rest home and hospital.</p> <p>Systems in place are appropriate to the size and complexity of the facility. There was an outbreak of norovirus in December 2016. During 2017, there were two outbreaks (respiratory in November and norovirus November 2017) which was contained to the studio apartments. There were no rest home residents residing in the apartments at that time.</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>There are current policies that reflect best practice and meet the restraint minimisation standard around restraints and enablers. The clinical manager is the restraint coordinator and has a job description that defines the role and responsibilities. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. One hospital resident was using a restraint (bedrail). There were no enablers on the day of audit.</p> <p>Staff receive training around restraint minimisation and managing challenging behaviours. Care staff interviewed were able to describe the difference between an enabler and a restraint. Care staff complete restraint competencies through the on-line health learn module.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The approval group meet three monthly.</p>



approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.  Ongoing consultation with the resident and family/whānau are evident. The file of the one hospital-level resident with restraint (bedrail) was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  The use of restraint is linked to the residents' care plans including the risks associated with restraint use, as identified in the restraint assessment. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form within the electronic resident file.  An on-line restraint register is in place providing an auditable record of restraint use and is up-to-date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use, and documentation is reviewed monthly and fully evaluated six monthly in conjunction with the six-monthly care plan evaluation.
Standard 2.2.5: Restraint	FA	The restraint minimisation programme is discussed and reviewed at the monthly restraint group meetings,

<p>Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>attended by the restraint coordinator (clinical manager) DT and facility manager, unit coordinator, RNs, health and safety officer (HCA). Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme, and staff education and training.</p>
---	--	--

## Specific results for criterion where corrective actions are required

---

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

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

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

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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service identified an opportunity to reduce falls in January 2017 by implementing falls prevention strategies for frequent fallers in the rest home. Falls rates have reduced from 20 to below 10 falls per month since May 2017.	The fall prevention programme action plan included discussion and education of staff, involving family in the review of resident footwear, decluttering rooms, prompting residents to use mobility aids as assessed, use of sensor mats and implementing intentional rounding. All RNs completed DHB health learn falls prevention training. All staff completed education and toolbox talks around falls prevention strategies with the educator. Manual handling training was completed for all staff by the physiotherapist. The DT has implemented changes to the programme to include a variety of physical activity designed to increase strength and balance such as helping the gardener with gardening activities, sit and be fit classes, beach ball and balloon tennis. Resident attendance has increased, and residents are now invited to advanced fitness classes. Monthly analysis identified a peak in falls in October 2017 due to two fallers diagnosed with delirium. This was followed by staff education around delirium. With the exception of two frequent fallers the rest home falls have continued to decline. The service has been successful in reducing falls in the rest home by 57%.
Criterion 1.3.7.1	CI	The 2016 resident	The service commenced a project in July 2016 to include more outdoor activities to be

<p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>survey of rest home residents identified an improvement around providing more interesting and meaningful activities. Many residents expressed an interest in gardening activities. The service saw an opportunity to further develop the gardens when planning the outdoor landscaping around the new hospital wing.</p>	<p>enjoyed in the newly landscaped gardens around the new hospital wing. The residents were involved in suggesting gardening activities and the gardener who has horticultural experience, attended resident meetings. Resources and activities included placing bird houses where residents could go outside and feed birds, make bird seed balls or observe the birds from inside. A greenhouse was installed, where residents plant and propagate seedlings, which are then planted in the raised kitchen garden. A rose walk was planted, and a rose naming competition held. Relatives and resident interviewed stated they enjoyed going for walks in the rose garden. Residents have joined in garden tours. Events have been held in the gardens including a BBQ lunch and A&amp;P show with animals and bowls on the lawn, Mexican day and a staff members wedding. The service has achieved its goal of increasing outdoor activities, including gardening for the residents. There has been an increase in rest home satisfaction with activities from 76% satisfied in 2016 to 90% in 2017. The hospital residents first survey in 2017 identified all residents were satisfied or very satisfied.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>The service identified an area for improvement around reducing the rate of urinary tract infections (UTIs). An action plan was developed that was successful in reducing UTIs in the rest home and hospital.</p>	<p>An action plan was developed in June 2017 to reduce UTIs in the rest home and hospital. Staff were informed and educated around the importance of hygiene, hydration and early reporting of any resident signs and symptoms of UTI. Additional fluids were offered in a variety of rooms including jellies, yoghurts and ice-pops. Slight increases in August and September were analysed, and where a resident was identified as prone to UTI a GP review was completed. A renewed focus also saw a decline in UTIs below the lower limit range of 1.5 per 1000 bed nights since July 2017 for rest home residents and for the last three months for hospital residents.</p>

End of the report.