

# Golden Pond Private Hospital Limited - Golden Pond Private Hospital

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Golden Pond Private Hospital Limited
<b>Premises audited:</b>	Golden Pond Private Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 23 April 2014    End date: 24 April 2014
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	54



# Executive summary of the audit

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## 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

Golden Pond Private Hospital provides rest home and hospital level care for up to 61 residents. The service is operated privately and managed by a registered nurse and there is a clinical nurse leader who oversees clinical activities. Both are experienced in aged care. Residents and families spoke positively about the care provided.

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

This audit has resulted in a continuous improvement in emergency management and identified four areas requiring improvements relating to staff not consistently undertaking correct signing of progress notes, medication management, the kitchen environment, toilet areas and sling hoist maintenance.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has processes in place that demonstrate commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of these rights was evident in their day to day practice during audit. Residents, family and whanau are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and advocacy services displayed and accessible throughout the facility.

Residents are provided with services that maximise their independence and reflect their and their family/whanau wishes. Policies and procedures are in place to protect the safety of residents and to ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori have their needs met in a way that respects and acknowledges individual and cultural values and beliefs. There was evidence of the recognition and respect of all residents' cultural identity, values and beliefs throughout the service.

Residents receive services appropriate to rest home and hospital level care standards. The service environment encourages good practice and staff strive to improve service delivery that reflects current best practice, undertaking projects to enhance wellbeing.

Staff communicate effectively with residents and work closely to ensure the environment is conducive to good communication. Open disclosure and clear communication was demonstrated with residents, family and whanau. Written consent is obtained where required.

Linkages with family/whanau and local community was evident. Residents have access to their visitors of choice.

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

## Organisational management

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

The quality and risk management system includes collection and analysis of quality improvement data and identifies trends. Data is benchmarked and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, relevant records are maintained in using an integrated record system. Archived records can be retrieved when necessary.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The service provides hospital and rest home care with clear criteria evidenced in the policies and procedures. There is a defined process for those declined entry. There was no evidence of declined residents at time of audit with all residents having appropriate assessments in place.

The service meets the requirements and timeframes for assessment, care planning, reviews, evaluations and the provision of care. The residents receive competent and appropriate services in order to meet their assessed needs and desired outcomes. Support plans are completed with residents soon after entering the service based on standardised assessments. Support plans were current and regularly reviewed.

The residents have risk and crisis management plans where needed. The service liaises closely with external services which was confirmed by the visiting mental health caseworker. Residents are supported to access other health and disability services, as appropriate, to meet their needs. Discharge or transfer is planned and coordinated to minimise any risks.

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

The residents are supported to maintain healthy lifestyles, enjoy nutritious and health meals. Residents with specific dietary requirements have these met. Menu plans are based on appropriate nutritional guidelines. There are several areas for dining made available.

Medicine management is completed safely. There is oversight by qualified clinical staff and staff who administer medicines have the required medication competencies with appropriate training and information available.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents and was clean and tidy. There is a current building warrant of fitness. Electrical and clinical equipment are tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken both onsite for smaller items and residents' personal clothing, and off-site for larger items of linen, and is evaluated for effectiveness.

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

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support safe restraint practice. Ten enablers and 11 restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

<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>Standards applicable to this service fully attained.</p>
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Golden Pond is a well-managed environment for infection prevention and control which is appropriate for the size and scope of the facility. Infection prevention and control is led by experienced and trained designated staff member. The programme is reviewed annually with specialist advice accessed.

Staff demonstrated good principles around infection control which is guided by policies, procedures and regular education updates and information.

Surveillance is undertaken and the results are reported through to the staffing teams. Follow up action is taken as and when required. There is benchmarking occurring with some other like providers.

## 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	46	0	3	1	0	0
<b>Criteria</b>	1	96	0	3	1	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>As observed on the days of audit, staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering residents' bedrooms, use residents' preferred names when speaking to them and ask permission prior to undertaking cares. Staff interviews confirmed they understand and respect the resident's right to refuse cares or interventions. Staff verbalised ways that they deal with situations that arise, and actions taken to ensure residents' rights are maintained. This was confirmed during interviews with residents and family/whānau members.</p> <p>The GP also confirmed that he was satisfied that Golden Pond recognise residents' rights and he had no concerns in this area.</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</p>	FA	<p>The informed consent policy provides clear detail on best practice and safe practice and Rights 5, 6, 7 of the Code. Guidelines are specific regarding obtaining informed consent and advance directives which identify voluntary and competent consent. Advance directives are reviewed on a regular basis. The resuscitation policy focuses on maintaining comfort and dignity and family/whanau are involved. Policy is discussed either prior to entry to the service or at admission.</p> <p>Signed consent forms were sighted in eight files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing. This was confirmed with both resident and family/whanau</p>

<p>choices and give informed consent.</p>		<p>interviews. The files reviewed had correctly signed advance directives or advanced care plans with residents chosen wishes related to resuscitation status and end of life status evident.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents, family/whanau confirmed they are actively encouraged to determine their care. Family felt comfortable advocating for their relative. Nationwide Health and Disability Advocacy Services advocates visit regularly. Contact details of this service was visible at the entrance to the service and family/whanau confirmed their knowledge of the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents confirmed they have access to visitors of choice. Family stated they always feel welcome, staff are friendly, and the facility has a 'nice feel to it'. They confirmed visiting can occur any time. Residents are encouraged to maintain links with their local community with outings arranged to maximise their contact. Residents go out regularly with family and friends. It was reported by the activities coordinator that community services such as the RSA, several local chaplains and entertainment groups attend the facility regularly. On the day of audit, the chaplain was in attendance and confirmed she visits at a minimum of once per week.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 14 complaints/concerns have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The manager is responsible for complaints management and follow up. The owner director is kept informed of all complaints and concerns.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> <p>One complaint resolution involved the Health and Disability Advocacy Service as requested by the provider, with no follow up actions required. There were no outstanding complaints at the time of audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are opportunities for explanations, discussion and clarification about the Code of Health and Disability Services Consumers' Rights (the Code) with resident/family/whanau as part of the admission process. Contact information and brochures from the Nationwide Health and Disability Advocacy Service was observed on a display board at the entrance of the facility and made available to residents and visitors. Residents, family/whanau reported that they are informed of their rights and that staff are respectful of these. Staff reported they receive training and education on advocacy, rights and complaints.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. All voiced they could articulate their needs in these areas and staff would respond. The chaplain attended the facility on the second day of audit to meet with identified residents.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room that reflects their individuality.</p> <p>Residents are encouraged to maintain their independence by attending activities of choice from a comprehensive programme. Residents and family interviewed voiced they had many opportunities both within and outside of the facility to maintain their independence, with one resident out at work for the week. It was evident throughout the audit that residents were participating in clubs and outings of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. The service has invested in the Golden Care on line activity programme which identified plans that reflected individuality and choice.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. The activities coordinator progress notes were also sighted.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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</p>	<p>FA</p>	<p>Maori residents have access to appropriate services and any barriers that have been identified by the organisation are resolved. The clinical leader reported that there were no issues for Maori accessing the service; currently five residents identify as Māori. Staff identifying as Māori are engaged in service delivery.</p> <p>Whanau involvement in all aspects of service delivery is recognised and supported. Staff reported that they receive cultural training and discussed how they support residents who identify as Māori to integrate their cultural values and beliefs. The clinical leader and registered nurse clearly articulated their knowledge of</p>

acknowledges their individual and cultural, values and beliefs.		the Maori Health Plan and the care provided to meet the cultural, spiritual and individual beliefs of residents. Files of the residents clearly identify cultural affiliations.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Policies and procedures provide clear guidelines to ensure resident's cultural identity is respected and recognised. Care planning includes cultural values and beliefs. Residents, family and staff confirmed they are consulted on their/or their relatives values and beliefs. Care planning is designed to meet their individual needs. Social, spiritual, cultural and recreational needs are met. Family/whanau are involved in all aspects of assessments, care planning and review processes.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff sign a code of conduct which covers professional boundaries and maintain behaviours that cannot be construed as discriminatory. There was no evidence of any concerns expressed by residents/family/whanau of any forms of discrimination coercion, harassment, and sexual, financial, or other exploitation.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	Regular in-service education and external education is accessed by staff and focused on best practice. Staff confirmed that good practice is encouraged, and ideas welcomed to improve current practice. Staff are supported by management to have access to policies and procedures, guidelines and ongoing education to enhance practice. Family/whanau confirmed high level of satisfaction with service delivery and the staff approach.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policy related to open disclosure is actively implemented with family/whanau confirming they are kept informed of resident's status, inclusive of adverse events, incidents or concerns staff may have. Family/whanau communication was evident in documentation. Family/whanau and residents reported high satisfaction with communication received.  There is access to an interpreter where necessary. Contact details were evident in resident's admission information and policy. No residents need an interpreter at the time of audit.

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, quality principles and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owner director showed adequate information to monitor performance is reported including incidents and accidents, food services, nursing, domestic, infection control, emerging risks and issues.</p> <p>The service is managed by a registered nurse who holds relevant qualifications and has been in the role for over 20 years. She is supported by a clinical nurse leader and an administrator who have been in their roles for 26 and 27 years respectively. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. Members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through ongoing education, such as attending age care meetings, DHB managers' meetings and clinical education both onsite and off-site.</p> <p>The service holds contracts with the Bay of Plenty District Health Board (BOPDHB) for Long Term Support-Chronic Health Conditions- Residential, Specialist Palliative Care Residential Beds, and Age Related Residential Care.</p> <p>A Ministry of Health (MOH) contract is held for Residential Non-Aged Care. At the time of audit two residents were receiving services under the Residential Non-Aged Care contract, four under Long Term Support, and 48 under Age Related Residential Care, being made up of seven rest home level care and 47 hospital level care. (One of the hospital care residents is an ACC client). The two dedicated palliative care beds were not occupied.</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>	<p>FA</p>	<p>When the manager is absent, the clinical nurse leader carries out all the required duties under delegated authority with assistance from the owner director as required. During absences of key clinical staff, the clinical management is overseen by the manager who is a registered nurse with a current practising certificate and is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and wounds, pressure</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>injuries and falls.</p> <p>Incident and accident information is benchmarked against other like facilities (Cavell Group) on a monthly basis. All trending of data and benchmarking outcomes are posted on the staff notice board.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff team meetings and is shared with the owner director. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Outcomes of quality and risk data including regular internal audit results are used to measure achievement against the quality and risk management plan. Any deficits sighted are followed up to show outcomes achieved. Examples sighted for the 2017-2018 period. The documented follow up ensured staff were aware, the actions to be taken were discussed at staff meetings, documented in the communication book and evaluation occurred to show positive outcomes were achieved.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (June 2017) showed residents and families were satisfied with services offered. The only comment made was that communication with families could be better. This was documented as a quality improvement and staff were reminded to notify all next of kin of changes in resident's condition, injuries, medication errors, and care planning changes. This information was also required to be documented in the communication sheet in the front of each resident's chart. No negative comments related to communication occurred during resident or family interviews and all residents' charts reviewed had a family communication sheet which was current. Regular monthly residents' meetings allow residents to raise any issues or concerns they may have. Interviews confirmed these are dealt with promptly and outcomes are reported to the next meeting.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current with review dates shown on the front page. Staff are informed of all policy and procedural updates in the communication book and at staff meetings. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The health and safety coordinator who has completed related education to level six, undertakes monthly environmental audits, maintains policies to reflect current changes and ensures all hazards are monitored and documented in the risk register. A monthly report is taken to management and discussed at staff meetings.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on various accident/incident forms. There are separate incident forms for falls, physical injury such as skin tears, medication incidents, needle stick injuries, staff injury and a general incident form. Samples of all types of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the manager and follow up actions and outcomes are shown on the forms as appropriate to each situation. Incidents and accidents are included in benchmarking data.</p> <p>The manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two section 31 notifications of significant events made to the Ministry of Health, since the previous audit. Actions taken related to both incidents are clearly documented. One involved a police investigation which is now closed the other was an aggressive resident. There have been no coroner's inquests, issues-based audits nor any public health notifications made since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of eight staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and that there is a 'buddy' system in place to ensure new staff always work with a senior staff member who will assist them with any issues or questions they have</p> <p>Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme.</p> <p>There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels shown on rosters match</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>the required staffing skills as shown on the interRAI level of care report. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>There are dedicated cleaning staff six days a week, laundry staff five days a week, two activities coordinators for 31.5 hours per week Monday to Friday and kitchen staff seven days a week.</p> <p>The clinical nurse leader works four days a week for eight hours, the nurse manager works five days a week and the administrator works three days a week all covering Monday to Friday and on-call as required.</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>PA Low</p>	<p>Information is managed in an accurate and timely manner. Health Information was kept in a secure area in the nurses' station. Information was not accessible or observable to the public. The eight files reviewed evidenced that entries into progress notes are made at least daily by the registered nurses but did not consistently evidence the staff member's name; the initials only were noted along with the designation. Records were legible for staff to read.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database.</p> <p>Archived records were secured on site and readily retrievable. Residents' files are held for the required period before being destroyed.</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 enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, and their family/whanau of choice where appropriate, local communities and referral agencies. The service has a pre-entry form which identifies the resident's required level of care.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. There is open communication between all services, the resident and family/whanau. The facility uses the DHB's 'yellow envelope' system to facilitate transfer to and from the acute services.. Any concerns are written on the form and discussed. Appropriate information is provided for the ongoing management of the resident at times of transition between services. All referrals are documented in the progress notes. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and copy of any advance directives that are in place.</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>PA Moderate</p>	<p>There are a range of policies that contain clear processes for all stages of medicine management to meet current best practice. The policy references guidelines and legislation. The guidelines include the robotic system in use, acquisition and storage of medicines, controlled drugs and self-administration of medications and administration of medicines. The service utilises an electronic medication system. On the day of audit, it was observed that the RNs do not consistently implement the medication management process according to policy and procedures with the RNs administering the medicines in a manner that did not demonstrate safe medicine management practices. It was observed that the RNs consistently leave the trolley unattended with medication clearly available to those walking past. There was evidence of medications being signed for as not given but no reason recorded or when asked the wrong reason identified.</p> <p>The medicines are supplied by a contracted pharmacy in the robotic sachet system and delivered monthly, with any changes by the GP delivered the same day as the change. The medications are checked for accuracy against the prescription by the RN. The GP conducts medication reconciliations on admission and at a minimum of three monthly which he signs on the resident's chart. All medications sighted were within current use by dates.</p> <p>All medicines and trolleys were stored in a locked medication room. The medication fridge is monitored and temperatures are recorded. Controlled drugs are stored safely in the medication room and signed out by two staff when given. A weekly stock count is recorded in the controlled drug register but not the required six monthly checks.</p> <p>Sample signature verification is recorded for all staff who administers medicines. A review of 16 medicine charts identified medication is signed by the GP. All prescriptions are computer generated by the pharmacy and they allow a safe medication management system to be undertaken. Prescriptions are legible, record the name, dose, route, strength and times of administration. Short term medications have a start and stop date. All charts sighted identify allergies and have a current photograph of the resident for identification. The RNs are responsible for medicine administration.</p>

		The RNs all have medicine competencies assessed annually. Those residents self-administering medications (6) had locked boxes in the rooms and evidence of documented competencies on file.
<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>	PA Low	<p>There is a range of food service policies which contain detailed information about nutrition and menu planning, safe food handling and storage. There was evidence that meal choices are available and the menu is reviewed annually by a registered dietician. This was confirmed by the head cook. The service is waiting for their submitted food plan to be verified. The menu is a four-week rotational menu with seasonal variations (summer and winter menu).</p> <p>Every resident has a dietary review on entry to the service and all residents are routinely weighed at least monthly, and more frequently when needed. Residents with additional or modified needs are met. There is evidence of diabetic and texture modified diets being clearly specified on documentation and the head cook confirmed changes in residents' needs are clearly communicated with them.</p> <p>A food satisfaction survey was undertaken in February 2018. Only one issue was raised and this has been addressed. Residents did not raise any concerns during interview. Residents and family confirmed satisfaction with the food service and that likes/dislikes are catered for.</p> <p>There is a cleaning programme in place for the kitchen and all aspects of food purchase, preparation, delivery and disposal are complied with to meet current legislations and good practice. Kitchen staff are qualified to undertake their role. The storage shelves were noted to be in poor condition and cannot be cleaned to meet infection/food control standards</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	When entry to service is declined, the potential resident, and where appropriate their family/whanau, are informed of the reason and of other options or alternative services. The pre-entry form records reasons for this, contact with client/family/whanau and options discussed. The clinical leader reports no residents have been declined if an appropriate assessment has been undertaken and a bed is available. There is a clause in the admission agreement related to when a resident's placement can be terminated. If the needs of the resident change and they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found.
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and</p>	FA	Needs, outcomes and goals are identified through the assessment process and documented to serve the basis for care planning and service delivery. The service uses the interRAI assessment process. Eight files reviewed have the interRAI assessment completed to develop long term care plan and reassessment

preferences are gathered and recorded in a timely manner.		occurs at least six monthly, or earlier if a change in needs. The service uses other appropriate tools and clinical pathways when not covered in the interRAI process (eg, wound and falls assessments).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The service utilises the Momentum care plan which is generated from the interRAI assessment tool. The clinical leader reported staff prefer this format having previously utilised a facility generated care plan. The long term care plan, short term care plan and clinical pathway identifies support and interventions to achieve desired outcomes. This was confirmed in the files reviewed. The rest home and hospital level care residents reviewed using tracer methodology have care plans and short term care plans describing the required interventions. All care plans are individualised and reflected the facility's person-centred philosophy. Staff confirmed the care plans ensured continuity of care. Residents and families confirmed they had confidence in the excellent knowledge and skills of the staff caring for them. The eight files reviewed clearly demonstrated service integration was occurring. The residents have one main file that contains medical, nursing, care planning, observations, activities, therapies, and multidisciplinary reviews, correspondence and off-site consultations. Electronic records are printed and maintained in the main file. Any change in care required is documented and verbally passed on to relevant staff.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Services and interventions contribute to meeting residents' needs and outcomes. Files reviewed confirmed individualised care planning and personalised care to reflect residents' needs. Care plans were generated using the interRAI process. Short term care plans and clinical pathways were used when there were special needs (eg, falls minimisation, end of life care). The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. This reaffirmed the facility's person-centred care approach. Care staff confirmed the care provided was as outlined in the documented plans. The care staff reported they can approach any RN or clinical lead if they feel concerned about any aspects of the care plan. The GP and the family/residents interviewed, verified that staff seek medical input in a timely manner and that care is delivered to a high standard. Residents and family members interviewed stated that they found that the staff were 'fantastic' and that the 'managers were available and approachable'.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The activities programme is provided by two rostered activities coordinators and volunteers. A social assessment and history is undertaken on entry to the service to ascertain needs, likes, dislikes and interests. The resident's activity needs are regularly reviewed to ensure the programme is meaningful to the resident. There is a regular evaluation undertaken on a three-monthly basis by the activities coordinator and at the formal six monthly care plan review undertaken with the RN.

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Activities offered reflect the residents' goals, ordinary patterns of life and included both internal and external community activities. Residents and families/whānau are involved in evaluating and improving the programme through residents' group meetings (chaired by a resident), satisfaction surveys and individual residents' meetings. The residents have copies of their programmes in their rooms. Families and residents are encouraged to participate by making suggestions to the programme.</p> <p>Periodically there are weekend musicians visiting. There are also volunteers to the facility who read, talk with residents and offer music. Church ministers are also weekly visitors. The chaplain was visiting at the time of audit. The activities coordinators spend individual time getting to know residents ensuring each person has regular visits by them to help formulate their understanding of the residents' preferences. The activities coordinators reported that she tracks when reviews are due with a newly developed spreadsheet.</p> <p>Residents interviewed confirmed they find the programme satisfactory and 'there is always something to do'. In the absence of the activities coordinator, there is a programme for the caregivers to follow and this ensures that something is offered over the weekends. Residents are encouraged to participate. There was evidence of a balanced approach to activities both internally and externally.</p> <p>The programme offered both from a group and individual perspective is suitable for all levels of care as activities are tailored to individual needs and goals.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If changes are noted, it is reported to the RN on duty. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents needs change.</p> <p>When progress is not as expected, the service responds by initiating changes to the long term plan or by using the short term care plans. Examples of short care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, acute conditions, falls and wound care. When necessary, or for unresolved problems, the clinical leader reported that the long term care plans are added to. Staff are informed of the changes.</p> <p>The family/whanau/residents confirmed their satisfaction with care provided and reported that they felt fully involved, were informed and had a good understanding of the care planning process. The evaluation of care is not in a specific section of the care plan, but various scales, indicators and outcome measures are embedded within each interRAI instrument and are used to evaluate clinical status. For each reassessment, data is collected and changes are evaluated and compared. Outcome measures were sighted in the eight files reviewed on the day of audit and evidenced to be used in the evaluations of progress towards outcomes/ goals. Examples sighted were activities of daily living scale, the aggression scale, body mass index, changes in health status, end of life stages, cognitive performance scale, communication scale, depression scale, pain scale and pressure injury risks scale.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referrals are made to other medical services by the RN or clinical leader or GP as seen in all files reviewed. Examples sighted were referrals to general medicine and surgical services, radiology, a dietician, mental health, ophthalmology, and specialist wound care. Family/whanau confirmed this on interview and voiced satisfaction with the service. The GP reported that the staff have good clinical knowledge and skills. He spoke highly of the clinical leader and manager and reported timely and appropriate referrals to other disciplines.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals, such as cleaning, laundry and kitchen staff, have undertaken safe chemical handling education. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness (expiry date 01 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (15 July 2017) and calibration of bio medical equipment (20 September 2017), lifting equipment (30 June 2017) was current as confirmed in documentation reviewed, interviews with management and observation of the environment. One sling hoist is in poor condition.</p> <p>Staff ensure the environment is hazard free, that residents are safe and independence is promoted. Monthly environmental audits are undertaken by the health and safety coordinator with any required follow up actions clearly documented. Results of outcomes are recorded including any items that are identified as new hazards.</p> <p>The communal bathroom and toilet areas in each wing have damage to the bottom of the doors and one</p>

		<p>shower wall has minor damage to the laminate walling.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents confirmed they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes five bedrooms with ensuites and 24 bedrooms that have a shared ensuite between two rooms (12 ensuites). Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Refer comments in criterion 1.4.2.1 in relation to maintenance.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely and to allow the use of lifting equipment as required.</p> <p>All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>



<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Resident personal laundry and hand towels are laundered on site in a dedicated laundry. There is a second smaller laundry which is used to wash kitchen linen. An off-site contracted provider launders the bed linen and large towels. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the chemical provider who provides the facility with a monthly report related to chemical usage.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disaster management and describe the procedures to be followed in the event of a fire or other emergency. The staff and management are actively involved in disaster planning for the greater community as well as the facility. The manager attends the Eastern Bay of Plenty Emergency Response Group meetings quarterly. In April 2017 there was a civil defence emergency in the Bay of Plenty which involved the Golden Pond Private Hospital. The actions taken and learnings from the disaster are clearly documented to show how this was successfully managed and what could be improved. Emergency management has gained a continuous improvement rating.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 08 September 1995. There have been no changes to the facility footprint since this time. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in December 2017. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and stated this worked very well during the cyclone emergency.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, portable lighting and gas BBQ's were sighted and meet the requirements for the 61 residents. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. As the system is an older style it is not able to be monitored electronically for call time response. The manager stated they regularly ask residents if the response time is appropriate. The service is looking at updating the call bell system and the manager is seeking costings for this to occur in the future.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time</p>

		and a security company checks the premises at night.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. All heating is electric. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is comprehensive infection control manual which contains policies on all expected subject topics. Golden Pond has just purchased a new infection control programme (2018) which will inform the infection control programme for the facility. The responsibility for infection control is clearly defined and there is a clear line of accountability for infection control matters. The infection control coordinator is the clinical leader who has a clearly defined job description that outlines the roles, responsibilities and accountability for infection control matters. The monthly and annual reports are provided to the owner/operator.</p> <p>There are annual reviews undertaken (evidenced for 2017) which covers quality improvements, policies, procedures, surveillance, standard precautions and education.</p> <p>There was clear signage in place for all infection control matters to reduce exposure to infections from staff, visitors and residents. The notice on the front door advises visitors not to have contact with residents if they are unwell. Residents may be isolated where possible and practical, if needed. There is a policy for staff not to come to work if they are unwell.</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>	FA	<p>The infection control meeting is incorporated into staff monthly meetings. The infection control coordinator presents the monthly infection control report at this meeting. Reports and surveillance data are placed on the staff notice board.</p> <p>The infection control coordinator has the skills, expertise and resources necessary to undertake the functions to achieve the standards. The coordinator participates in local and regional infection control networks and forums. The facility can access expertise and resources through the DHB and local advisory services. The infection control coordinator can also access advice through the GP, product suppliers, Ministry of Health and diagnostic services if needed.</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>	FA	<p>There are written policies and procedures for the control and prevention of infections which comply with good practice and legislative requirements. The service utilises policies and procedures from an infection prevention and control specialist service provider. These policies and procedures are referenced and accepted as current good practice. The facility has access to newsletters and education through the advisory service to ensure current practice is relevant and staff knowledge is current. Infection control objectives are reviewed annually, and these are reported against at monthly infection control meetings and in the annual report.</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>	FA	<p>Infection control education is provided by a suitably qualified person who maintains their knowledge on current best practice. The infection control coordinator and external specialists conduct the education. The infection control coordinator attends the infection control forums when they are made available and undertakes training to ensure practice reflects current best practice.</p> <p>Resident education is undertaken and recognises the preferred communication method and style of the resident. The infection control coordinator has had education with the residents on flu vaccinations, shingle vaccinations and any individual specific infections related to their needs.</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>Golden Pond, through the infection control committee determine the type of surveillance required and its frequency. Surveillance is based on what is acceptable definitions for aged care services. There is monthly surveillance for respiratory, skin, urine and gastroenteritis infections. Results of surveillance are acted upon, evaluated and reported to the relevant personnel and management. The monthly data is collated and analysed by the infection control coordinator.</p> <p>The infection control coordinator reported that their rates of infections are low in comparison to the facilities they benchmark against. The infection control coordinator reported they had changed the hand gels. There is low antibiotic use, endorsed by the GP, and RNs manage infections per treatment guidelines. The service also uses Cranberry juice at lunchtime for high risk residents and for those with indwelling</p>

		catheters. This was sighted as being given for those identified in care plans.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, 11 residents were using restraints and seven residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. (Three of the seven residents had two enablers, one being a bedside rail and the other a chair lap belt for safety).</p> <p>Restraint is used as a last resort and alternatives are explored. The restraint coordinator stated that some bedside rail restraints are in place as they have been requested by enduring power of attorneys. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the restraint coordinator, clinical nurse leader and the manager, are responsible for the approval of the use of restraints and the restraint processes. All restraint approvals are signed off by the resident's GP. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care and identified in the interRAI assessment process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. Restraint and enabler use is also documented under mobility in the interRAI assessment process. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The RN restraint coordinator described the documented process during interview. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the</p>

		resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint or enabler.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The restraint coordinator described how alternatives to restraints are discussed with staff and family members. For example, the use of sensor mats, low beds and landing strips. However, it is noted that many families insist that bedside rails or chair lap belts be left in place.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details and monitoring occurs from between half hourly to a maximum of two hourly according to risk. (Refer comments in standard 1.2.3).</p> <p>Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. (May 2017). Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, at six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of</p>

of their use of restraint.		staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. This was evidenced by data reviewed, meeting minutes and interview with the restraint coordinator.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	<p>Eight records were reviewed and found to be legible. The records did not demonstrate required legislative requirements or good practice as some RNs were found to be signing only with initials and designation. The person making the entry was not identifiable.</p>	<p>Staff do not consistently sign residents' progress notes with their full name, but rather use initials and designation.</p>	<p>Staff sign progress note documentation using their full name and designation.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,</p>	PA Moderate	<p>The controlled drug register provided evidence of weekly stock checks but not the six monthly mandatory checks being undertaken. This practice was confirmed by the clinical leader.</p> <p>During the medication rounds it was observed that the RN staff left the medication trolley in the corridor out of their sight with medications sitting on top of the trolley openly visible and accessible. These medications could have been removed without the knowledge of the RN. Any medication</p>	<p>The mandatory six-monthly checks have not been undertaken by the service. The RNs were observed undertaking medication administration practices that did not follow policy or legislative requirements in relation to security of medications during medication rounds and recording of the</p>	<p>Provide evidence that RNs ensure safe medication practices in relation to security of medications during the medication round and recording of reasons for refusal. Mandatory six monthly controlled drug checks</p>

protocols, and guidelines.		that was refused was entered incorrectly into the electronic medication system using an incorrect reason. This was confirmed by the clinical leader as against policy and practice guidelines.	reasons for medications refused.	are completed.  30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The head cook advised that due to the poor condition of the shelving, evidenced by flaking paint, they cannot be cleaned to the expected standard and limit storage availability.	Storage shelving is in poor condition evidenced with flaking paint, limiting kitchen storage areas and the shelving cannot be cleaned to meet infection/food control standards.	Provide evidence that the poor shelving condition has been remedied to improve storage and that infection/food control standards are maintained.  180 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The building warrant of fitness is current. Electrical testing is undertaken annually or as required, and biomedical equipment is checked by an approved provider. Whilst the hoists have been checked within the last year, one sling hoist is in a poor state of repair with paint chipped and rust on the lower joints.  The communal bathroom and toilet areas in each wing have damage to the bottom of the doors and one shower wall has minor damage to the laminate walling. The owner director stated the service is waiting for contractors to come and fix these items.	One sling hoist has rust on the lower joints and chipped paint on the frame. This cannot be cleaned to meet infection control requirements.  The doors to the communal showers and toilets located in each wing have damage at the bottom of the doors and one shower wall has a small hole in it. The damage does not allow cleaning to be undertaken to meet good infection control standards.	Provide evidence that the sling hoist and bathroom areas can be cleaned to meet infection control cleaning standards.  180 days



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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	CI	<p>Service providers receive information and training related to all emergency. This includes education related to civil defence emergencies for the greater community and the facility (June 2017). Fire equipment is checked by an approved provider annually. This last occurred in August 2017.</p> <p>Having fully attained this criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those finds, and improvements have been made to further ensure resident and staff safety during an emergency. Documentation identifies that emergency readiness of the facility allowed them to manage and continue services to meet residents' needs safely during a cyclone in April 2017. This occurred two weeks after nearby areas had been flooded and this had affected staffing levels as some staff were unable to come to work. The day before the cyclone the facility was alerted that the cyclone was heading their way. Actions taken included:</p>	<p>All civil defence actions were put into place as soon as the service was alerted to an impending cyclone. Services were maintained to ensure resident care was provided in a safe manner to meet their needs. All processes undertaken are clearly documented so that actions that went well can be replicated and learnings about what could be done better have been actioned to ensure any further emergencies can be managed in a more informed manner.</p>

	<ul style="list-style-type: none"> <li>- The removal or securing all outdoor items</li> <li>- Hard copy medication forms were printed and medication tablets with medication information was backed up so it could be documented manually.</li> <li>- Oxygen cylinders were checked to ensure they were full.</li> <li>- The memorandum of understanding with three other facilities was checked to ensure they could assist with temporary accommodation for residents should an evacuation be required.</li> <li>- Transportation of residents was organised with a bus company who had mobility bus access should a full evacuation be required.</li> <li>- A staff contingency plan was put in place to cover staff who may not be able to get to work.</li> <li>- The owner director remained at the facility during the civil defence alert.</li> <li>- Civil defence processes and equipment were prepared.</li> </ul> <p>Power was lost on the 13 April 2017. Telephones worked to ring out from the site using a manual plug in phone which is part of the civil defence equipment. Residents were given spoons to bang should they need a staff member. Staff maintained frequent rounding throughout the crisis. Additional oxygen bottles were obtained from the DHB.</p> <p>Residents who required the use of lifting equipment remained in bed with frequent cares occurring including regular changes of position.</p> <p>The kitchen managed with gas BBQs and portable gas burners. No food was lost as food temperatures for frozen foods was maintained.</p> <p>Learnings from the emergency identified:</p> <ul style="list-style-type: none"> <li>- more oxygen regulators were required and have been purchased.</li> <li>- incoming phone calls could not be received and a dedicated cell phone number for staff to report their availability to work is to be implemented.</li> <li>-The debrief concluded that civil defence supplies could be strengthened by the use of disposable pans which fit in the toilets.</li> </ul>	
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		<p>These have been purchased and have replaced toilet liner plastic bags in the civil defence supplies.</p> <ul style="list-style-type: none"> <li>-The need to hire a chemical toilet for staff use is being considered.</li> <li>-There was a more than adequate battery supply for torches and the use of glow lights and handheld LED lights proved to be invaluable.</li> <li>-The staff contingency plan worked well and staff and management were able to maintain most services. Staff were very proud of the teamwork and peer support displayed during this time.</li> </ul>	
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End of the report.