

Papatoetoe Residential Care Limited - Papatoetoe Residential Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Papatoetoe Residential Care Limited
Premises audited:	Papatoetoe Residential Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 April 2018 End date: 18 April 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	25

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

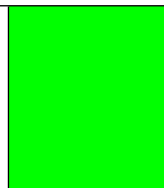
Papatoetoe Residential Care Ltd provides care for up to 30 residents requiring aged residential rest home and hospital level care. At the time of this audit 25 beds were occupied. Twenty-two residents are receiving hospital level care and three residents are receiving rest home level care.

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

There are five areas identified for improvement related to consistently linking infection prevention and control and restraint minimisation data to the quality and risk programme, staff appraisals / ongoing education, wound management processes / documentation, caregiver medicine competencies for checking medicines, and residents self-administering medicines.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

The complaints process aligns with the requirements of the Code. Complaints are rare, and when received are investigated and responded to in a timely manner.

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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The organisation's philosophy, mission and vision statement are documented, along with goals. The executive director (who is one of the facility owners), the facility manager and the clinical nurse leader work together to ensure service planning covers all aspects of service. The services offered meet residents' needs, legislation and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, benchmarking, hazard and risk management, resident satisfaction surveys, and regular resident and staff meetings. Corrective action planning is documented.

New staff have an orientation relevant to their role. Ongoing education is provided at least monthly. Records of attendance are maintained. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing which is implemented. There is a registered nurse on site at all times.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. Medicines are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance. There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire drills.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no significant changes to the facility since the previous audit except for some refurbishment.

The facilities meet residents' needs and provide furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. There are adequate toilet, bathing and hand washing facilities.

The lounge and dining areas meet residents' relaxation, activity and dining needs. Appropriate external areas are available for residents' use. The facility is kept at a suitable temperature. Opening doors and windows creates an air flow to keep the facility cool and ventilated when required.

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 service has a commitment to being restraint free wherever possible. The restraint minimisation and safe practice policy and definitions complies with the standard. There were no restraints in use during audit. One resident had an enabler approved for use

at the time of the audit and written consent for use was on file. Staff are provided with ongoing education on managing challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken and results reported. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	3	1	0	0
Criteria	0	88	0	3	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. There is also a copy of the residents' Code of Rights in each of the resident's bedrooms.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record and</p>

		<p>residents and family are encouraged to support this process with written information provided at the time of admission. Of the 25 residents, one resident had an advance directive that was completed prior to their admission. A further 12 residents are deemed competent but do not have an advance directive. There was evidence of a further 11 residents deemed incompetent. Of those 11, four residents had evidence of enduring power of attorney documentation with another four residents admitted with no enduring power of attorney in place and further evidence sighted of two residents' families in the process of organising and enacting EPOA. There was one resident supported by a legal guardianship.</p> <p>Staff were observed to gain consent for day to day care. Resuscitation was discussed at the time of admission with the GP and at the six monthly multidisciplinary review meetings. Residents and family interviewed reported they were happy with the support that staff provide for example day to day conversations and different options provided.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical nurse manager was able to provide examples of where they would encourage the involvement of Advocacy Services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their discussions with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood,</p>	FA	<p>Papatoetoe Residential Care Ltd implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family</p>

<p>respected, and upheld.</p>		<p>and staff reported they were aware of the complaints process and noted they had no complaints. A compliment/complaint or suggestion form is readily available to residents and family members without being requested. These are located in a wall mounted holder near the main entrance.</p> <p>A complaints register is maintained and associated records were verified. Complaints were investigated and responded to in a timely manner. The facility manager is responsible for complaints management. Very few complaints are received. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code (in Maori and English) is displayed in reception and alongside the nurses' station together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room or share a room with another person with their consent.</p> <p>Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur at initial orientation and training, last held in</p>

		March 2016.
<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>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers acknowledging the four cornerstones of Maori Health which include Whanau (family health), Tinana (physical health), Hinengaro (mental health) and Wairua (spiritual health). There are three residents who affiliate with their Maori culture and evidence of staff acknowledging and respecting the resident's individual cultural needs was integrated throughout the resident's care planning and activities. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The residents' and families were unable to be interviewed at the time of audit, however evidence of regular communication was sighted in the residents' files.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed and discussed at six monthly multidisciplinary meetings with residents and family. The kitchen staff provided an example of this by supporting a resident who does not eat pork due to their cultural beliefs, thus the facility have brought and use clearly identified and separate meal plates and cutlery for the resident's specific use. Another example is sighted in the consent form and activities plan of a resident where, due to their spiritual values and beliefs, they do not want to be included or acknowledge and celebrate certain activities that occur in the facility. The resident satisfaction survey and interviews with residents and family members confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by</p>

		policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included knocking on residents' doors before entering, day to day conversations between staff and residents and visiting family members.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There are four residents for whom English is their second language; however, these residents are able to understand a little English. Staff know how to access interpreter services, although reported this was rarely required due to families who are very supportive, available by phone and also visit frequently. Staff know the residents well and are also able to provide interpretation as and when needed and are supported by the use of cue cards.</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>	FA	<p>Papatoetoe Residential Care Ltd has a documented mission statement, philosophy and values that is focused around the provision of individualised, quality care where residents' independence is maintained along with respect, privacy and dignity. Freedom of choice</p>

	<p>is valued and individual needs identified and met in order to enhance each resident's quality of life.</p> <p>The executive director is one of the two business owners. The executive director is a chartered accountant and has worked in the aged residential care sector for many years, prior to purchasing this rest home in June 2011. The executive director has been on site for at least two days every fortnight or more frequently when covering for managers' leave and will be on site three days every three weeks moving forward. The executive director is available by phone, text and email when not on site. The management team monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities. The executive director receives monthly reports from the facility manager and meeting minutes. Delegations of authority are documented, and these include the executive director having approval of policy and procedure changes. The executive director has been appointed to the board of directors of a large regional health service since the last audit.</p> <p>A new facility manager was appointed in July 2017. The facility manager trained as a registered nurse, however no longer maintains an annual practising certificate. The facility manager has 20 years' experience in real estate prior to having management roles in two other aged care facilities, before being employed at Papatoetoe Residential Care Ltd. The facility manager is responsible for the day to day operations and ensuring the wellbeing of residents is the responsibility. The facility manager participates in relevant ongoing education as required to meet the provider's contract with Counties Manukau District Health Board (CMDHB).</p> <p>The clinical nurse leader (CNL) has been employed in this facility since prior to the current owner's purchase, working nine days a fortnight. The CNL is responsible for providing oversight of clinical care. The CNL shares on call with another senior nurse, each rotating and having a week on call and a week off call. The CNL has a current interRAI competency, and current annual practising certificate.</p> <p>The service has a contract with CMDHB for the provision of aged related rest home and hospital level care, as well as a contract for the provision of residential respite and long term support (chronic care conditions). A contract with the Ministry of Health for residential non</p>
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		aged care is also in place. There are four residents under the age of 65 years receiving care. One is funded by Accident Compensation Corporation (ACC). The other three are receiving hospital level care. There were no residents receiving respite care during audit or receiving services under the oversight of the DHB mental health services.
<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	The CNL is responsible for oversight of care in the facility manager's absence. The CNL was able to detail the responsibilities of the second in charge. The delegations of authority document (April 2016) details the delegations that are in place between the executive director, the facility manager and other applicable staff. The executive director advises she is accessible and available to the CNL as required, and will visit more frequently if the facility manager is away for longer absences of two or three weeks.
<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>	PA Low	<p>Papatoetoe Residential Care Ltd has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, benchmarking, health and safety reporting, hazard management, infection control data collection, restraint minimisation and complaints / compliments management. Regular internal audits are conducted and the results of eight audits sampled demonstrated a high level of compliance with organisation policy. A review of falls data has recently occurred.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions were developed and implemented. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. However, infection / surveillance data and the information on the use of restraint and enablers is not noted as discussed at the recent staff meetings.</p> <p>Meetings are held every month with residents to obtain resident feedback on services, food, and activities as well as obtain information for future planning. The minutes of the last four meetings were sighted for residents, along with the results of the recent residents' satisfaction survey (March 2018). The feedback from residents in the satisfaction survey was predominantly positive. The results are yet to be collated to analyse themes. A food satisfaction survey was conducted in April</p>

		<p>2017.</p> <p>Policies or standard operating procedures (SOP) were readily available for staff. Some policies have been developed by an external consultant (who was previously the facility manager) and localised to reflect the needs of the facility. The majority of policies / SOPs have been developed by Papatoetoe Residential Care Ltd and reviewed and updated as required. A paper copy of policy manuals is available for staff. The facility manager is responsible for document control processes. The approval process for policies is defined. Documents sighted were current.</p> <p>Staff, resident and family interviewed expressed a high level of satisfaction about the services provided at Papatoetoe Residential Care Ltd.</p> <p>Actual and potential risks are documented and reviewed. Mitigation strategies have been documented. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date. Maintenance issues are reported as issues are identified. Staff health and safety representatives have been elected and are working with staff to improve H&S practices. The Health and Safety Committee was re-established in December 2017. Minutes have been documented for the most recent monthly meeting (10 April 2018). Registered nurses meet monthly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>A standard operating procedure details the required process for reporting incidents and accidents. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as of the ongoing education programme, and during staff meetings</p> <p>Applicable events are being reported in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by residents and all family members interviewed. A review of reported events including falls, skin tears, a bleeding ear, medicine errors, and two pressure injuries demonstrated that incident reports are completed, investigated and responded to in a timely manner. Wound care plans are not always sufficiently detailed or monitored (refer to 1.3.3.3). However, the corrective actions required were noted on the reverse of</p>

		<p>every incident report sighted. Staff communicated incidents and events to oncoming staff via the shift handover. A summary of events was discussed with staff at the staff meetings.</p> <p>The service is benchmarking the number and type of events with other aged residential care facilities. The benchmarking programme was sighted, and data entered reflected the incident reports sighted on site. Papatoetoe Residential Care Ltd is well positioned in relation to the other facilities in the data sighted.</p> <p>An essential notification was made in July 2017 related to the change in facility manager. Another essential notification is being finalised by the facility manager as at audit. The executive director and the facility manager detailed the other type of events that require notification. There have been no events requiring reporting to the Coroner.</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>PA Low</p>	<p>Copies of the annual practising certificates (APCs) were sighted for the two general practitioners (GPs), the CNL, the 16 pharmacists, the podiatrist, the physiotherapists and all the registered nurses (RNs). The APC on file for the two dietitians had an expiry date of 31 March 2018. The dietitians are reported to have not been on site since this time. The facility manager advised updated copies will be obtained prior to their next visit.</p> <p>Recruitment processes include completing an application form, conducting interviews and reference checks. Police vetting is occurring for new staff at employment. Staff have a job description on file. The job description / employment contract and confidentiality documents include a statement advising staff of privacy / confidentiality requirements. Performance appraisals have not occurred in some of the applicable staff files sampled.</p> <p>New employees are required to complete an orientation programme relevant to their role. A workbook is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. A new RN reports being buddied for three weeks before being rostered shifts on her own. Staff are required to complete orientation requirements within three months of employment. Staff meeting minutes contained reminders to staff of the required processes.</p>

		<p>A staff education programme is in place with in-service education provided monthly. Records are not available to verify that restraint minimisation / use of enablers, abuse and neglect and pressure area prevention / management have occurred in the staff training programme for 2017 and 2018 to date as scheduled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements, and this aligns with the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB).</p> <p>The current roster was reviewed. Staffing aligns with policy. The roster issued contains the RN and housekeeping services roster for a two week period. Caregivers' rosters are issued weekly. Where there are changes in hours worked or staffing is different to that noted on the roster, these changes are recorded on the roster. The rosters sighted demonstrated that there is a registered nurse on duty every shift. Four days a fortnight, an additional RN is rostered on the morning shift (from 7 am to either 1 pm or 2 pm) to enable the CNL to undertake management activities. Where required, the night RN stays later into the morning to assist with the morning medications. This has been a recent development.</p> <p>Only registered nurses are able to administer medications. The caregivers are involved with checking some medications before administration. There is no ongoing competency assessment process in place for caregivers related to medicine checking. This is raised as an area for improvement in 1.3.12.3.</p> <p>The clinical nurse leader and a senior RN share being 'on call' rotating week about. All registered nurses including the CNL have a current first aid certificate.</p> <p>The administrator works 40 hours a week (Monday to Friday). The executive director assists with this role when the administrator is on leave.</p> <p>There is a minimum of two staff on site overnight from 10.45 pm or 11 pm to 7 am. This comprises a RN and one caregiver.</p> <p>All except six caregivers have a current industry approved qualification or equivalency based on long standing experience in the aged</p>

		<p>residential care sector. Some of the staff have been working in this facility for over 20 years. Due to this, there are challenges covering unplanned absences and planned leave with less experienced staff.</p> <p>Five caregivers are rostered on morning shifts with finish times staggered between 1 pm and 2 pm. An additional caregiver is rostered on duty between 7 am and 11 am if there are more than 27 residents receiving care. Four caregivers are rostered on the afternoon shift starting at 3 pm with finishing times staggered between 9 pm and 11 pm. An additional staff member is rostered from 5 pm to 8 pm when more than 27 residents are receiving care. Where the occupancy is under 27 residents, all but one caregiver each shift (excluding nights) works 15 minutes less.</p> <p>The activities coordinator works 7 hours a day Monday to Friday. The activities coordinator also has a current first aid certificate. The cleaner is rostered six hours a day Monday to Friday and two hours on the weekend days. A cook is rostered for eight hours a day seven days a week. One cook works weekdays and the other cook on the weekend. A kitchen hand is rostered to work at least seven and a half hours each day (seven days a week). Maintenance / gardening is provided by a contractor. All laundry is outsourced to a commercial laundry service. Laundry is returned washed and folded.</p> <p>Residents and the family member interviewed confirmed their personal and other care needs are being well met. Residents verified their call bells are answered in a timely manner.</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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during</p>

		the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. 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. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility in February 2018 showed the required paper-work accompanied the resident to the acute setting. Prior to the transfer, progress notes documented that the facility had contacted the emergency triage nurse who accepted the resident, and the family had been contacted. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged care.</p> <p>A system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and</p>

		<p>responsibilities related to each stage of medicine management.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff when administering; however caregivers do not hold medication competencies to support the required checking of medications administered by the registered nurses. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines. The facility offers the flu vaccine and consent forms were sighted, however vaccines are not stored on site.</p> <p>There were eight residents who were self-administering medications at the time of audit; however, not all appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by one of two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service is awaiting the approved Simply Safe and Suitable template provided by the Ministry for Primary Industries and is</p>

		<p>aware that they must register with the local council by the 31st May 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan which includes a soft diet option for morning and afternoon snacks to support residents whom require a modified diet. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents have current interRAI assessments completed by one of three trained interRAI assessors on site. There is a wound log and wound management plan however the identification, assessment, intervention and evaluation for wounds and pressure injuries is not always documented in applicable sampled files. Residents and families confirmed their involvement in the assessment process.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. There is a wound log and wound management plan however the identification, assessment, intervention and evaluation for wounds and pressure injuries is not always documented in applicable sampled files (refer to criterion 1.3.4.2). Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that staff provide good communication between residents, family and health professionals. The GP reported that overall a good level of care is provided. Care staff confirmed that care was provided as outlined in the documentation and discussed at handover. There is a wound log and wound management plan however the identification, assessment, intervention and evaluation for wounds and pressure injuries is not always documented in applicable sampled files. (please see criterion 1.3.4.2). A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities co-ordinator who supports residents Monday to Friday from 9.30 am to 5.00 pm.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-</p>

		<p>monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions with residents, satisfaction surveys and residents' meetings. There are three residents who are independent in attending daily and weekly community events and families are also supported to take their resident out on the weekends to attend their cultural and spiritual choices. Residents and family interviewed confirmed they are supported in their/their relative's individual needs and find the programme provided at the facility interactive. The residents reported that they look forward to the activities making specific reference to bowls and bingo.</p> <p>The activities co-ordinator interviewed reported that she visits each resident every morning and encourages them to attend the planned activities. Residents that prefer to spend time in their rooms have the option of one to one time with staff. Resthome and hospital level care residents mix regularly in the dining room for meals and in the lounge and dining room when activities are occurring.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections; however, wound and pressure injuries management plans did not always have evidence of evaluations of wounds documented (see criterion 1.3.4.2). When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services, a dietician, and a speech language therapist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Standard operating procedures detail how waste is to be segregated and disposed. The document content aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Wall safety charts detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been provided with training on chemical safety and handling. Waste management has been discussed at staff meetings as verified in meeting minutes sighted.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, and masks. Emergency kits with PPE is also available for use in an outbreak or other significant event.</p> <p>Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system and confirmed receiving education on handling chemicals and waste.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current building warrant of fitness (BWOFF) with an expiry 16 March 2019. Ongoing checks to maintain the BWOFF are occurring. Another company undertakes performance monitoring and electrical safety checking (where applicable) of clinical equipment including hoists and scales. Electrical equipment sighted had evidence of current electrical testing and tag checks. Clinical equipment had a current performance validation. Maintenance requests are identified and documented by staff when issues are noted.</p>

		<p>The facility vehicle has a current registration and warrant of fitness.</p> <p>Four residents have a deck area off their bedroom that they can access. There are ramps outside that facilitates residents to mobilise outside in electric wheelchairs or using other mobility aids. Grab rails are present in the corridors and bathrooms. Residents were observed to be mobilising independently including with the use of a mobility device in their bedrooms, throughout the rest home communal areas, and outside areas. Internal audits detail that the temperature of hot water is below 45 degrees Celsius in the results of the monthly tests sighted (since November 2017).</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>Hand basins are present in each resident's bedroom. Waterless hand gel is also available for staff and residents at locations around the facility. There are four separate showers and four separate toilets for residents' use. There is also one combined shower and toilet. Two bedrooms have a shared ensuite.</p> <p>There are separate bathroom facilities for staff to use.</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>Twenty six residents' bedrooms are single occupancy, and two bedrooms are share twin. The rooms all contain space for the residents, personal possessions and use of mobility devices, if required. Residents were sighted mobilising inside the rest home independently, including while using a mobility aid.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</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>Most residents have single occupancy rooms. There are a number of other areas that residents can use for activities or to meet with family and friends. This includes the lounge and dining room, and the external / garden areas. The residents and family members interviewed confirmed that there was sufficient space available for residents and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and</p>	FA	<p>Policies detail how the cleaning and laundry services are to be provided. Laundry services are contracted to an off-site commercial laundry. This includes the washing of residents' personal clothing. On</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>admission, residents can pay a fee to the laundering service to personally name every item of the resident's clothes with name tags that are not affected by the washing process, Resident's personal clothing is washed, folded and returned. Staff check the garment labels to ensure items are returned to the correct resident. Some family members prefer to wash the resident's clothes at home.</p> <p>The residents and family members interviewed confirmed the rest home is kept very clean and tidy. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services. The feedback from residents was very positive. Chemicals are stored in designated secure cupboards / rooms which are locked. A cleaner, identified being provided with training on the safe handling of chemicals, and had written instructions readily available on the use of products and required cleaning processes / activities.</p> <p>Instructions for managing emergency exposures to chemicals is readily available to staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 10 June 2000. The most recent fire evacuation drills were conducted in November 2017 as part of the staff education programme. Twenty-one staff attended this education session.</p> <p>Policy documents provide guidance for staff on responding to civil emergency and disaster events.</p> <p>Review of the staff files and training records verified that registered nurses are provided with first aid training. A registered nurse is on duty at all times.</p> <p>There are sufficient supplies available of dry food, lighting, torches and batteries, and other clinical supplies for use in emergency. A gas hob for cooking is available along with spare blankets. A 1000 litre water tank is onsite that contained sufficient supplies for use in emergency. The water is treated monthly and changed annually. Other emergency supplies are checked and rotated as required.</p>

		<p>Call bells are present in the bathrooms and residents' bedrooms. They alert via an audible sound, and notification through to a centralised panel. Two call bells tested at random were fully functioning. Other call bells were heard during the audit that were attended to promptly.</p> <p>Visitors entering the building are directed via signage to come to the main entrance. All doors are locked at designated times, although staff and family advise they are given access if presenting after this time. An intercom and camera are present at this door to enable staff to identify visitors before granting access. No concerns were expressed by residents or the family member interviewed about security arrangements. Another door is used for ambulance access. Caregivers advise they are required to visually check each resident at night and lock the doors / windows at 7pm and again on shift handover to the night staff. These checks are documented in the security book.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms have a window. Four bedrooms open out onto a deck area, Heating is via wall mounted electrical heaters in the older part of the building, or via underfloor vented gas heating in the newer part. Obtaining feedback on the environment is a component of the resident satisfaction survey. Residents and family members interviewed verified the facility is keep warm and ventilated. Smoking is only allowed in a designated outside area for the one resident that currently smokes. Processes are in place to ensure cigarettes are extinguished safely.</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>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GP as required. The infection control programme and manual are reviewed annually.</p> <p>The clinical nurse manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and executive director, and tabled at the quality/risk quarterly committee meeting. This committee includes the general manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or</p>

		has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
<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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for ten years. She has undertaken study days in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has</p>

		included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.
<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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager and executive director, however is not reported to all staff (see criterion 1.2.3.5). Benchmarking has provided assurance that infection rates in the facility are below average for the sector. For the period of October 2017 – March 2018 the facility recorded a total of 64 infections, seven of those residents with a combined total of 28 infections were identified requiring frequent antibiotics. Appropriate interventions in the residents' care plans were sighted to minimise and reduce the risk of infections.</p>
<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. The service has a restraint free philosophy wherever possible. The definitions of restraint and enablers align with the standards. The restraint coordinator (the clinical nurse leader), provides support and oversight for enabler and restraint minimisation processes, and demonstrated understanding of the organisation's policies, procedures and practice, and the restraint minimisation coordinator role and responsibilities. Caregivers interviewed could describe enablers and restraints.</p> <p>One resident has an enabler consented for use. A written consent form is on file. A process is in place for monitoring the use of enablers. However, this has not been required as yet as the resident has yet to participate in the activities that the enabler has been consented for use.</p> <p>On the day of audit, no residents were using restraints. All staff interviewed advised restraints have not been used 'for some time'.</p>

		<p>Monitoring of restraint and enabler use had previously been included as an agenda item in the staff meeting. However, this is not included in the discussions in recent meetings sighted (since December 2017), as the agenda / minute template has not been used. This is included in the area for improvement raised in 1.2.3.5.</p> <p>The staff training programme includes restraint minimisation on the annual calendar. However, while training has occurred on managing challenging behaviours (September 2017), records verifying education on restraint minimisation and the use of enablers was not available for 2017 and 2018 to date. Training on this topic had been scheduled for July 2017. This is included in the area for improvement raised in 1.2.7.5.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept informed of incident and accident data, resident feedback and complaint / compliments. The minutes of recent staff meetings sighted from December 2017 to April 2018 includes (but is not limited to) discussion on incidents / accidents, staff induction /orientation and ongoing education, waste management, staff conduct, night security, resident feedback, health and safety, and pressure area prevention. Discussion related to infection surveillance activities / results and the use of restraints and enablers is not reflected as occurring in the minutes sighted. The previous minute template that explicitly includes these components has not been used in</p>	<p>Key components of service delivery including restraint minimisation and infection prevention and control is not explicitly linked to the quality and risk programme. Staff meetings no longer include these topics in the minutes sighted.</p>	<p>Ensure infection surveillance data and the use of restraint and enablers is explicitly linked to the quality and risk programme.</p> <p>180 days</p>

		recent months.		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A staff education programme is in place with in-service education provided monthly. The topics are scheduled over a calendar-year and align with Papatoetoe Residential Care Ltd contract with CMDHB. Education provided in 2017 and 2018 year to date includes (but is not limited to); fire safety, civil defence, managing challenging behaviours, Alzheimer's, palliative care, privacy, communication, documentation, infection prevention and control, use of personal protective equipment (PPE), health and safety, manual handling, safe food handling, the Code of Rights, and Treaty of Waitangi / cultural safety. Education is provided by the CNL, facility manager, H&S consultant, and the fire safety consultant. Staff can also attend relevant external education. Records of education are maintained and copies of some education certificates are present in the staff files reviewed. Not all planned education has occurred including abuse and neglect, restraint minimisation and use of enablers, and pressure injury prevention.</p> <p>Staff are required to have annual performance appraisals. These are overdue for six out of 12 applicable staff files sampled. The sample size was expanded to review this aspect. There is currently no process to identify when appraisals are due for individual staff</p>	<p>Annual performance appraisals are not consistently occurring. A schedule detailing when staff appraisals are due has not been developed.</p> <p>Records were not available to demonstrate that ongoing staff training on restraint minimisation/use of enablers, abuse and neglect, and prevention and management of pressure injuries has occurred annually as scheduled in 2017 and 2018 to date.</p>	<p>Ensure a process is in place to identify when staff are due annual performance appraisals and undertake these. Ensure staff receive training on all applicable topics.</p> <p>180 days</p>

		members.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA</p> <p>Moderate</p>	<p>All registered staff are medication competent. There is one registered nurse on all three shifts with an overlap of the night registered nurse staying till 8.30 am to support the morning registered nurse with medications. At other times, the care staff are responsible for the checking of medications including controlled drugs. The care staff interviewed were able to discuss the required checks and processes when administering medication however the care staff have not completed a medication competency to show competence with these tasks.</p>	<p>Caregivers do not hold medication competencies to support the checking of medications administered by the registered nurses.</p>	<p>Provide evidence that all staff who hold medication responsibilities undergo competency assessments to perform the function they are assigned.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA</p> <p>Moderate</p>	<p>At the time of audit, eight residents who were self-administering medications, did not have an assessment to demonstrate competence to do so. The medications (inhalers) were not stored securely, nor could staff show evidence that residents were asked if they had taken their medications. In discussions with staff, it was evident that the residents were competent in the self-administering of their medications. The GP had completed three monthly reviews, but competency related to self-administration of medications was not included.</p>	<p>Eight residents' had not been assessed by the registered nurse and GP to show that they were competent to self-administer their medications safely. There is no ongoing process to monitor that medicines are being self-administered as prescribed.</p>	<p>To provide evidence that residents' who are self-administering their own medications are assessed as competent and meet the recommended medication guidelines for self-administering medications. Implement a process to monitor that patients are self-administering their medicines appropriately.</p> <p>90 days</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>There are nine current wound management plans relating to five residents (three residents have one wound; two residents have two wounds and one resident has three wounds) identified in the wound management folder. Four of five wound care management plans did not show all required evidence of assessment, planning and/or evaluation or have unique identifiers for multiple wounds. Two residents' frequency of dressing required, one residents expected timeframe of wound healing, three residents' documentation of actual wound dressing changes and/or progress was not identified. One resident admitted in December 2017 with a chronic wound did not have a wound care management plan developed until 13 days after admission. Five registered wounds had not been seen by the GP however the wound management policy does not stipulate that the resident is required to see the GP within a required timeframe if a wound or pressure injury occurs, nor does the policy document when a referral should be considered for specialist support. All chronic wounds are photographed with written consent and there was evidence of referrals and evaluations from specialists for example district nurse (re specialised dressing and support) vascular surgeon and wound clinical nurse specialist and follow-thru of requests from specialists by the facility. The clinical nurse</p>	<p>The identification, assessment, intervention and evaluation for wounds and pressure injuries was not always documented in applicable sampled files</p>	<p>To provide evidence of assessment, planning, provision, evaluation of wound care plans.</p> <p>180 days</p>
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		manager reported that although the documentation does not show evidence that all wound management is up to date, she is aware of the residents with wounds, that all the wounds are been dressed as required, reported in handover and referrals made as necessary.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.