

# Henrikwest Management Limited - Craigweil House

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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 HealthShare 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:** Henrikwest Management Limited

**Premises audited:** Craigweil House

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 20 June 2018 End date: 21 June 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:** 47

# 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Craigweil House can provide care for up to 68 residents requiring rest home, hospital, or dementia level of care. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures and residents and staff files; observations and interviews with residents, family, management, staff, and a medical officer.

There is a managing director, general manager and other support managers who work across the three facilities of Henrikwest Management Limited. There is a clinical manager on site who provides clinical oversight and day to day oversight of Craigweil House.

Improvements are required to the following: the quality and risk management programme; identification of the facility manager; orientation and training for staff; publicly observable resident information; assessments and long-term care planning and documentation of individualised interventions; monitoring of weight loss; laundry processes; security of chemicals; documentation of controlled drugs and checking of impress stock; care of some residents requiring hospital level care; the potential for restraint of residents and monitoring of any use of restraint.

## 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 receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their physical privacy and promote their independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up-to-date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete.

## Organisational management

<p>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.</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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There are annual business, quality, and risk management plans in place and these define the scope, direction and objectives of the service and the monitoring and reporting processes.

The clinical manager is a registered nurse with a current practising certificate.

There is a documented quality and risk management system in place. There are a range of policies, procedures, and forms in use to guide practice. Quality outcomes data is collected and tabled at relevant meetings. An internal audit schedule is in place with audits completed as per schedule. Adverse events are documented.

The human resource management system is documented in policy with recruitment completed as per policy. There is an annual training plan in place and staff have annual performance appraisals.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, hospital, and the dementia unit. An appropriate number of skilled and experienced staff are allocated to each shift.

Resident information can be stored securely when not in use.

## 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>		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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Registered nurses are responsible for the provision of care and documentation at each stage of service delivery. There is sufficient information gained through the initial support plans, risk assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The general practitioner reviews residents medical needs in a timely manner.

The diversional therapist implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

An electronic medication management system is implemented. The registered nurses and healthcare assistants who administer medications have annual competency assessments and received annual training. Medication records are reviewed every three months by the general practitioners or when necessary.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

## **Safe and appropriate environment**

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>	
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All building and plant complies with legislation with a current Building Warrant of Fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes calibration of equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the manoeuvring of mobility aids. There is a dementia unit that has specifically identified secure indoor and outdoor areas for residents. Outdoor areas are available for residents in the rest home and hospital units.

Essential emergency and security systems are in place with regular emergency drills and staff training completed.

## **Restraint minimisation and safe practice**

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>	
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation and around management of challenging behaviour. During the audit there were three residents using restraints and one resident using an enabler.

## 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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection prevention and control education. Surveillance data is collected, collated, and discussed in staff meetings.

## 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	39	0	3	8	0	0
Criteria	0	87	0	5	9	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

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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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	<p>Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training schedule (refer standard 1.2.7). Staff interviewed can articulate knowledge of the Health and Disability Commissioner's Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice.</p> <p>The service provides information on the Code to families and residents on admission. Residents and family interviewed stated that they believe their rights were met as per the Code (refer standard 1.2.3 for additional information).</p>
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>There is an informed consent policy. Consent is included in the admission agreement and sought for appropriate events and treatment. Staff were observed to use verbal consent as part of daily service provision. Staff interviewed demonstrated an understanding of informed consent processes.</p> <p>Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission. Consent forms are shown to them on admission and thereafter as relevant. All residents' files reviewed include documented written consent. It was noted that the</p>

		<p>enduring power of attorney signs the consent form for residents in the dementia unit.</p> <p>Residents deemed competent by the general practitioner have the choice to make an advanced directive. In records reviewed, all competent residents have an advanced directive. The resident signs these. The general practitioner has made a decision for some residents as not for resuscitation with this noted as being a clinical medical decision.</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>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident's family and chosen social networks.</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>There are no set visiting hours and family report that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services independently or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community. The service encourages the community to be a part of the residents' lives in the service with visits from entertainers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints although not all feedback is investigated (refer improvement identified in standard 1.2.3 and 1.2.3).</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Residents and family confirmed that they are informed by the managers that they can talk with them at any time. Training on the complaints policy and process is part of the staff orientation programme and ongoing education.</p> <p>The complaints register records the complaint, dates and actions taken if resolved including complaints received from the district health board (DHB). A request to follow up complaints during</p>

		<p>this audit was forwarded to the auditors from the DHB. Key areas were reviewed as part of the audit. A response to the DHB around actions taken was sighted during the audit. The DHB has since raised a separate complaint. The managers were not aware of this complaint.</p> <p>A complaint independent to those raised by the DHB was tracked and indicated that the complainant was responded to as per timeframes in policy with documentation of resolution. There are a number of corrective actions raised in this report that address issues identified in the complaint.</p>
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility including pamphlets available for residents and family in the dementia unit and hospital. Information around advocacy services and the Code is included in the admission information pack and described by the clinical manager as being discussed with residents and relatives on admission. Residents and relatives interviewed confirmed that the Code, the advocacy services were explained on admission.</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.	FA	<p>There are a range of policies and procedures to ensure residents are treated with respect. Staff endeavour to maximise residents' independence by encouraging residents to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit.</p> <p>The service ensures that each patient has the right to privacy and dignity. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Staff report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Practices consistent with this were observed on the days of the audit. Residents and families confirmed that physical privacy is respected (refer standard 1.2.9 regarding resident records).</p> <p>Staff state that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and can describe signs and reporting requirements. There were no incidents of abuse nor neglect reported in incident forms reviewed nor any documented on the complaints register. Residents, staff and family interviewed confirmed that there is no evidence of abuse or neglect. The general practitioner (GP) interviewed confirmed that there was no evidence of abuse or neglect.</p>

		There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.
Standard 1.1.4: Recognition Of Māori Values And Beliefs  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.	FA	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in when supporting residents who identify as Maori. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection, and participation.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.</p> <p>Staff interviewed described how they asked residents and family who identify as Māori, to describe what their needs are. The assessment and care plan identifies cultural needs. Strategies to support Māori to feel welcome described by staff included speaking in Te Reo for residents who identify with this as their language of choice if possible.</p> <p>Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori.</p>
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	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that staff respect their values and beliefs.</p> <p>The staff emphasised a focus on using signs and body language for residents who have difficulty communicating. Staff also described using simple language and giving simple choices for residents who have dementia.</p>
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in policy and job descriptions.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional</p>

		boundaries, including the boundaries of the caregiver role and responsibilities.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	<p>There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff.</p> <p>The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery (refer standard 1.2.7). Staff interviewed confirmed that the facility is a learning environment that meets their needs.</p> <p>Family members interviewed confirmed they are very happy and satisfied with the care provided to their relatives and expressed a satisfaction with the care delivered.</p> <p>The directors are members of the New Zealand Aged Care Association and the Care Association New Zealand with conferences attended.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>There are policies covering communication, access to interpreters and management interviewed reported that they have an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff. Resident meetings are conducted.</p> <p>The incident and accident forms include an area to document if the relatives have been contacted. Open disclosure is practised and documented when family are contacted. The general practitioner interviewed reported satisfaction with communication from staff.</p> <p>There is a policy around use of interpreters and access to interpreting services is documented. Staff can describe how they would access interpreting services if required.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Moderate	<p>The owners of the service also own two other facilities. The managing director purchased the first service in 2001, a second one in 2004 and this one in September 2017. The managing director provides overall management of the facilities with the general manager providing operational management over three facilities.</p> <p>The business has agreements in place with Waitemata District Health Board (WDHB) for the provision of aged residential care, the provision of Long Term Supports-Chronic Health</p>

		<p>Conditions, and an agreement with the Ministry of Health for Residential Non-Aged care. All residents were identified as being under the Aged Care Contract on the day of audit. One resident was identified as being a young person under the age of 65 years.</p> <p>Of the 68 beds identified as being certified, 28 are identified as dual-purpose beds; 20 as being rest home beds only and 20 identified as being for residents with dementia requiring a secure unit. On the days of the audit, there were 47 residents including 14 requiring rest home level of care; 21 requiring hospital level of care and 12 requiring dementia level of care.</p> <p>The purpose, values, priorities, and goals are documented in the annual business plan for 2017-2018. These goals are then included in the quality and risk management programme. The goals are reviewed annually.</p> <p>At the initial meeting, the general manager stated that they had been in the company for over five years with three years as the quality manager and two and a half years as general manager over all sites. The general manager has a Bachelor of Business Management and a background as quality manager prior to current roles. Staff, family and the general practitioner raised a lack of clarity around who was in the role of facility manager as the previous facility manager had moved out of the service.</p> <p>A regional administration manager is appointed across all sites. They have been with the company for 13 years with previous experience as an overseas registered nurse (not registered in New Zealand). They have held their current position for two years and hold a role in collating and monitoring results of internal audits. An office manager is based at Craigweil and is responsible for oversight of administrative tasks.</p> <p>The clinical manager (registered nurse) is employed full-time and has been in the role since July 2017 with 13 years previous experience in nursing in aged care including clinical and management experience in dementia and psychogeriatric units. The clinical manager provides clinical oversight with the general manager stating that they also provide day to day overall management of the facility. All managers including the clinical manager have completed at least eight hours of education in the last year relevant to their roles.</p>
Standard 1.2.2: Service Management  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	FA	During the temporary absence of the general manager, the managing director is available and experienced to cover the service. If the clinical manager was on leave, then an identified senior registered nurse would be able to provide clinical oversight. The registered nurse who would provide cover if the clinical manager was interviewed and was aware of that role. The registered nurse interviewed also has a sound knowledge of rest home, hospital, and dementia levels of care.

consumers.		
Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	<p>There is a quality and risk management framework that is documented to guide practice. This includes a business quality plan that is reviewed annually. The philosophy of the service is documented.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to review by the external consultant, with input from the managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy. A document control system is implemented and this ensures that documents are approved, up to date, and managed to preclude the use of obsolete documents.</p> <p>Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The internal audit schedule is documented annually with audits completed as per schedule with the administration manager providing oversight and reporting on audit results. An improvement is required regarding the completion of clinical audits.</p> <p>The schedule of meetings includes the expectation that the meetings are held monthly. While some are held monthly as scheduled, there are others that include the laundry, kitchen and activities meetings that are not held as scheduled. An agenda for each meeting ensures that all elements of the quality and risk management programme can be discussed. An improvement is required regarding implementation of the meetings schedule. Residents and family have also indicated that they would like more frequent meetings and this has been noted as a recommendation.</p> <p>Data is tabled at the meetings however there is insufficient evidence in meeting minutes to confirm that data is analysed and discussed with recommendations leading to improvements in service delivery or organisational management. At times corrective action plans are documented and/or there is evidence of resolution of issues at following meetings however this is not consistently completed. Resident meetings are held quarterly and family can attend if they wish. Improvements are required regarding analysis of quality related data and the corrective action process.</p> <p>Staff reported that they are kept informed of quality improvement and risk management through meetings.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management</p>

		<p>programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise and risks are eliminated, minimised or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents, and clinical issues are discussed through meetings as part of the health and safety programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported with these signed off by the clinical manager.</p> <p>The incident forms show evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirmed that incidents are reported in a timely manner. The sample confirmed that incidents and accidents are closed following review by the clinical manager and linked to the quality system with documentation of data at relevant meetings (refer standard 1.2.3 regarding the analysis of quality data).</p> <p>The clinical manager could describe the statutory and/or regulatory obligations in relation to essential notification reporting and can describe the process of notification to the correct authority where required.</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>	PA Low	<p>There is an established system in place for human resource management. All staff records sampled include an employment agreement and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education however documentation of the orientation programme does not sufficiently differentiate training around the different levels of service and an improvement is required.</p> <p>There is an annual training plan with training held monthly. Training records are maintained with staff signing to confirm attendance. Some sessions are well attended and others have low attendance. An improvement is required to ensure all staff receive the required training.</p> <p>Performance appraisals are completed for all staff who have been employed for 12 months or more and this ensures that any individual training needs are identified.</p> <p>There is a registered nurse on each shift. The registered nurses hold current first aid certificates with evidence of these being current in staff files for registered nurses reviewed. Two registered</p>

		<p>nurses are interRAI competent including the clinical manager and another registered nurse. Medicines are given by registered nurses and health care assistants who have been assessed as competent in the rest home and dementia unit only.</p> <p>One staff member working in the dementia unit has completed training in dementia. There are six who have nearly completed training (currently completing the last module) and three enrolled (new staff). The nine staff nearly completing or enrolled in training are newer staff or new staff who will complete training within the timeframes documented in the DHB agreement. There is a potential gap in knowledge in the meantime given the number of staff who have yet to complete training however staff interviewed on the day had a sound understanding of the philosophy of the unit; knowledge of managing challenging behaviour and understanding of offering resident's choice. Staff working in the dementia unit are also supported by a registered nurse on each shift who can provide support and ongoing training in the unit. The clinical manager provides support and advice.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. Staff rosters are developed by the clinical manager and the administration staff. Rosters and staff interviewed, and observation on the days of audit, confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the contract with the District Health Board. There are seven casual health care assistants who are available to pick up extra shifts when staff rostered are on leave with a review of rosters confirming that staff are replaced if absent.</p> <p>There is a registered nurse on duty with a current first aid certificate on each shift. The clinical manager is on site Monday to Friday and on call for clinical emergencies/concerns. A registered nurse also provides an on-call service with staff stating that they can call for assistance at any time. Staff stated that on call staff respond promptly.</p> <p>Staffing is allocated to each area. There are three health care assistants in the rest home on the morning (one short shift; two in the afternoon (one short shift) and one caregiver overnight. There are two health care assistants in the dementia unit in the morning and afternoon and one overnight. In the hospital area, there are four health care assistants in the morning (one short shift); three health care assistants in the afternoon and one overnight. The registered nurse relieves the health care assistant in the dementia unit so breaks can be taken.</p> <p>Staffing numbers have been reduced since the change in ownership after a review of the numbers of residents, acuity of residents and contractual specifications. Care staff interviewed state that they can complete tasks on each shift and that the staffing currently meets their needs in relation to the ability to provide care to individualised residents. There are now 48 staff employed including</p>

		<p>the clinical manager (40 hours a week); diversional therapist (full time, caregiver who provides activities two days a week, activities coordinator for over six hours one day a week with an advertisement for another activities coordinator; five registered nurses; six household staff; 20 health care assistants plus seven casual health care assistants.</p> <p>The administration manager is on site two days a week and the general manager is on site two days a week.</p>
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	<p>Each resident has an individual integrated record (containing all records documented by staff and other health professionals) with those reviewed indicating that they are maintained. All records are maintained confidentially with these locked in a secure area when not in use. The nurses station has a large window that looks out onto the hallways. A white board details resident information and this can be publicly viewed from the hallways and an improvement is required. A record of past and present residents is maintained electronically. InterRAI assessments are completed by the clinical manager or a registered nurse. Progress records are documented by the care staff in the paper-based record. The date, time, signatures, and designation of those entering into the records is legible.</p>
Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	<p>Craigweil House has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents are screened prior to entry and a record is kept of all admissions and any enquiries to the organisation. The facility information pack is available for residents and their family and contains all relevant information.</p> <p>Residents interviewed confirmed they receive information prior to admission and have the opportunity to discuss the admission agreement with the assistant manager or clinical manager. The admission agreement form in use aligns with the requirements of the Aged Residential Care (ARC) contract. Each resident, family or enduring power of attorney has been asked to sign a new admission agreement as part of the process of purchase of the service. This has been completed with some additional costs included. Residents were also asked to have a credit in a personal spending account and it is noted that this is voluntary.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	<p>There are policies in place to ensure the discharge of residents occurs as required. Residents who require admission to hospital are managed appropriately and relevant information is communicated to the DHB. The facility utilises the DHB approved system when transferring</p>

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		residents to the hospital. Relatives are notified if a transfer occurs. Care staff described providing a verbal handover to another facility if this occurs to ensure continuity of care. Scheduled hospital appointments are also discussed with the other facility as required.
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	<p>The medication management policies and procedures are documented and reviewed annually. The medications are securely locked in the medication room. Medication administration practice complies with the medication management policy, for the lunchtime medication round observed. There were no residents self-administering medications on the days of audit although a policy is documented to guide practice should this occur.</p> <p>A new electronic management system for documenting administration of medicines was implemented in April 2018. Staff have been trained in the use of this system.</p> <p>A reconciliation process is implemented and medications are checked on arrival. Any errors are recorded and fed back to the supplying pharmacy. Registered nurses are competent to administer medications to residents requiring hospital level care and healthcare assistants assessed as being competent can administer medications to residents requiring rest home or dementia level care. Competencies sighted confirmed that registered nurses and health care assistants giving medication on the day were designated as being competent.</p> <p>The medication fridge is checked daily with temperatures within the range identified in policy. The fridge is locked to secure medications. Eye drops are dated when opened.</p> <p>Controlled drugs are checked by two people and the register is checked weekly and every six months. Improvements are required in relation to the management of controlled drugs and medication stock takes.</p> <p>Medication records were sampled. All charts were legible, up-to-date, and reviewed as required by the GP. There was photo identification on each medication record and allergy status was recorded. 'As required' medications had prescribed indications for use recorded. Pain assessments are conducted when staff administers analgesia and controlled drugs.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	<p>There is a well-equipped kitchen and all food is cooked on-site. The chef works Mondays to Fridays. The evening meal is prepared by the chef and the healthcare assistants heat and serve. There is a food service manual in place to guide staff.</p> <p>There is a four-weekly seasonal menu (last reviewed by a dietitian last December 2017). A resident nutritional profile is developed for each resident on admission and provided to the kitchen</p>

delivery.		<p>staff (refer standards 1.3.4 , 1.3.6.1 and 1.3.5). The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. Temperatures recorded are within normal range as identified in policy.</p> <p>There is special equipment available for residents if required. All food is stored appropriately. Meals for the hospital and dementia units are transported in an insulated bain marie.</p> <p>Special diets are provided including pureed food and soft diets. It was noted during lunch time in two areas where lunch was taking place, that serving plates are of small size for all residents. Residents interviewed, however, were happy with the quality, amount and variety of food provided noting that food services had been reviewed following previous concerns raised by residents and family. It was noted during mealtime that residents were able to ask for extra with sandwiches and fruit also available. Observation of meals in the dementia unit and discussion with the staff on duty at lunchtime indicated that they observed residents closely and offered extra food to residents with encouragement for them to eat.</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>The managing director reports that they have not declined any resident because they provide three levels of care (rest home, hospital and dementia). Each resident has a needs assessment prior to being accepted and this guides placement into the facility.</p> <p>If an entry was declined, the reason would be documented in the enquiry form and the potential resident would be referred to the referring agency for appropriate placement and advice. The enquiry/decline to entry form was sighted.</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 Moderate	<p>Files sampled indicated that information around personal needs is gathered during admission. Residents and relatives interviewed confirmed that they had input into the entry process. InterRAI assessments are completed within three weeks after entry to the service. Standardised risk assessment tools are completed on entry to the service and at six monthly intervals. InterRAI assessments are completed six monthly and identifies key issues for each resident. Equipment provided is relevant to resident needs. This includes supplies of continence products and staff interviewed state that they do not run out of supplies for residents.</p> <p>Improvements are required to the sequence between completing the interRAI assessment and care plans and ensuring all assessment data is reviewed. A focus on assessment of weight loss is required.</p>

<p><b>Standard 1.3.5: Planning</b>            Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Files sampled had long term care plan in place. The long-term care plans describe general strategies and interventions for the residents (refer 1.3.6.1). Individualised strategies and interventions have not been consistently documented to meet individual needs identified through the assessment process and an improvement is required.</p> <p>Residents and families report that they are involved in the care planning process. Short-term care plans are developed when acute conditions are identified. For example, infections. Staff interviewed report that they read the care plans regularly. Each resident has an integrated record, and this demonstrates service integration.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b>            Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Registered nurses and healthcare assistants can describe cares for each resident. Generalised interventions and strategies are required to be documented. At times the information is included in care plans and at other times this is verbally handed over to other staff. Care staff report progress for each resident at handover at the end of each shift.</p> <p>A wound assessment and wound management plan is in place for residents with wounds. All wounds have been assessed, reviewed, and managed within the stated timeframes. The long-term care plan for each refers to the wound management plan. Registered nurses and the clinical manager interviewed stated that they could access the DHB wound nurse specialist when required. There was evidence in files of the referral of the residents to the wound specialist.</p> <p>Monitoring forms are in use as applicable for example, vital signs, wounds and behaviour (refer standards 1.3.4 and 1.3.5).</p> <p>Staff interviewed confirm they have access to sufficient wound management supplies and continence products. The dressing trolleys are well-stocked as well as the continence products cupboard as sighted during the audit.</p>
<p><b>Standard 1.3.7: Planned Activities</b>            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>	FA	<p>A full time diversional therapist is employed from Monday to Friday to provide activities for the residents. Health care assistants assist with activities in the weekends. Each resident has an individual activities assessment completed on admission. Activity plans are developed from information gathered in the activities assessment and interview with the resident/family on entry.</p> <p>Interventions related to activities were detailed for the specific resident and were age appropriate. There is a 24-hour activity plan for each resident in the dementia unit. The activity plans are evaluated every six months with an assessment and activity care plan updated (refer to standard 1.3.4).</p>

		<p>There are a wide variety of activities offered for the residents. The activities timetables are displayed in the units and in the main entrance (rest home, hospital, and dementia unit). There is a van outing with weekly trips to places of interest. Special events like birthdays, Father's Day and mid-year Christmas are celebrated. Some residents attend activities of their own interest in the community. Church services are provided during the month.</p> <p>Residents who prefer to stay in their room have one-on-one visits for discussion about topics of interest, hand massage and music. Residents are free to choose whether they wish to participate in the group activities. Participation is monitored.</p> <p>Residents can come and go from the facility as they please. Residents who are able, regularly visit the local cafes and shops and were observed to go out on audit days.</p> <p>Health care assistants reported they are aware of the resident's needs and interest. The registered nurses are aware of appropriate external resources to support the residents.</p> <p>Residents interviewed who attend the programme stated that it meets their needs and confirmed that attendance was voluntary. The programme observed in the dementia unit was particularly inclusive of residents and residents appeared to be enjoying the wide range of activities. Activities were also observed to occur for residents in the rest home and hospital.</p>
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	<p>Long-term care plans in new care plan templates are in place in all reviewed resident's files however, there was insufficient evidence of evaluation of the previous long-term care plans and an improvement is required.</p> <p>Short-term care plans were developed when acute conditions were identified. There is evidence that short-term care plans were evaluated. Registered nurses reported that they change the interventions when the desired outcomes are not met. Progress notes are documented at every shift by the health care assistant and the registered nurse documents in the progress notes at least daily for residents using hospital level care. The registered nurse writes a summary in the progress notes for residents in the dementia or rest home at least once a week.</p>
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service	FA	The clinical manager and registered nurses can refer a resident to non-medical services with the GP referring any resident to other medical services and medical specialists as required. Referral documentation is maintained on resident files. The registered nurses initiate referrals to nurse specialists and allied health services. Referrals and options for care are discussed with the family, as reported by the clinical manager, and registered nurses and as confirmed by residents and family members interviewed. Evidence of referrals to appropriate specialists including those in the

providers is appropriately facilitated, or provided to meet consumer choice/needs.		DHB was sighted in files reviewed.
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></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>Policies and procedures specify labelling requirements including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis. The health care assistants demonstrated knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. Cleaners in the dementia unit were particularly vigilant around keeping chemicals in sight when in use (refer standard 1.4.6.3).</p> <p>Personal protective equipment/clothing (PPE) is available. Staff confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required. Staff state that they do not run out of supplies.</p> <p>Waste is mostly of a domestic-type and is managed via a recycling programme or by local council contracted services. An external contractor collects medical hazardous waste.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness which is due to expire February 2019.</p> <p>The rest home and hospital are connected under one roof with the dementia unit having a separate roof line. The dementia unit connected to the hospital unit by a covered walkway. The hospital and dementia units are purpose-built units with the rest home being an older building. The maintenance person and contractors implement planned and reactive maintenance. There were no bad urine smells lingering during the audit.</p> <p>There is a planned and reactive maintenance programme in place. A review of the log of maintenance issues identified that these were addressed promptly and signed off in a timely manner. The preventative maintenance schedule is signed off when completed with this reviewed at regular intervals throughout the year.</p> <p>The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents. The electrical equipment is checked and records maintained. Testing and calibration of medication devices occurs annually.</p> <p>The service has vehicles that can be used for transporting residents. There is a system for managing the vehicle warrant of fineses and current registrations.</p>

		There are outdoor areas available for all residents including verandas and outdoor garden areas in the secure dementia unit.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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.	FA	There are sufficient toilets, hand basins and showering facilities available for residents. Most bedrooms have a hand basin, except for two. The rest home has communal toilets with some containing showers. The dementia unit has large shared bathrooms with toilets and showers. The hospital includes some bedrooms with an ensuite. There are appropriate privacy protections in place when showers and toilets are in use with these observed to be used on the days of audit.
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	PA Moderate	All residents have their own room except for three rooms in the rest home room which are double rooms that can accommodate couples. Couples are each able to have privacy in their room if required noting that these were not used as double rooms on the days of audit.  The hospital rooms have double doorways for beds and easy hoist access if required. There is room for mobility aides to be used safely in most resident's rooms. Two rooms were noted to be too small to safely manage equipment and lighting required.  Residents confirmed that there is sufficient space in each room for personal items apart from family who commented on one of the hospital rooms that had insufficient space to manage equipment.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large lounges in all units including the dementia unit. There are smaller rooms available throughout the building with comfortable seating for family/visitors and group meetings. The lounges are also used for activities. Each area has a dedicated dining room. There is a sunny enclosed sunroom in the rest home adjoining the rest home lounge that is utilised by residents.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services	PA Moderate	There are separate laundry and linen service manuals available containing all relevant cleaning and laundry policies and procedures to guide staff. Staff know how to access the information and can describe implementation as per policy. There are material data sheets available for all chemical products used for cleaning and the laundry. The cleaning and laundry service is

<p>appropriate to the setting in which the service is being provided.</p>		<p>monitored through the internal audit programme to ensure resident and relative satisfaction is maintained. Residents and relatives interviewed confirmed satisfaction with the cleaning and laundry services.</p> <p>The service employs cleaners seven days a week. All cleaning processes are documented clearly for each area of service. There is adequate storage for all chemicals in locked designated areas however some communal or other areas have chemicals in them. An improvement is required to ensure all chemicals are safely stored at all times. There is a cleaning schedule in place with documented daily cleaning tasks to be completed.</p> <p>Laundry is performed by dedicated staff seven days a week. There is a large laundry on site that contains commercial grade washing machines and clothes dryer and there is an outside washing line which is used as much as possible. There is dirty and clean separation in the laundry however on the day of audit there was a clean box with linen located in the dirty area and an improvement is required. Staff could describe procedures including soaking and washing of soiled and/or infectious linen.</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>There is an approved evacuation scheme dated 12 July 2012. There is an evacuation plan that supports staff and residents to exit the building in an emergency. Emergency drills take place every six months as required. Annual training is also provided on emergencies and security from a health, safety, and reporting perspective.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, linen, continence products, torches and batteries, water, gas heaters, and a gas stove. Food dry stock and frozen foods are available.</p> <p>An electric call bell system is available throughout the three units. All rooms checked during the audit had a call bell with residents in their room having access to this (by their bed or placed beside them if in a chair). The call bells in the dementia unit can be heard and identified by staff in the hospital. A sample of call bells tested on the days of audit were operational.</p> <p>Security is maintained. The dementia unit is secured with a door with key pad entry. On the first day of audit it was noted that the door did not close completely although an alarm was activated if the door did not properly close. This was identified as an issue and by the second day the door had been fixed. There is a perimeter fence that has doors with key pads on two gates.</p> <p>Staff on the afternoon and night shifts are responsible for ensuring that all doors and windows are closed appropriately, and doors are locked to prevent intruders. The facility manager, person on call or emergency services can be contacted if staff are concerned or if an emergency occurs.</p>

		Visitors who come after hours can contact staff if they wish to enter.
Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors and extraction systems. Heating is managed by use of heaters in the hallway in the rest home and some residents have individual electric heaters in their rooms which are checked by the electrician and tagged appropriately. A built-in heating system heats the hospital and dementia unit.
Standard 3.1: Infection control management  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.	FA	Craigweil House has an infection control programme that is reviewed annually. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control coordinator. The infection control coordinator has support from all staff and the general practitioner as confirmed by the general practitioner when interviewed. Internal audits have been conducted and include hand hygiene and infection control practices. Infection prevention and control is included in the orientation programme for all new staff. In-service education is provided annually.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources in place to implement the infection control programme. The infection control coordinator states that they can get support from the GP. The infection control coordinator reported that they can seek advice from the DHB infection control nurse when needed. Infection prevention and control is part of staff orientation programme. Hand washing facilities are available throughout the facility and hand sanitiser is freely available. There are also adequate supplies of gloves, continence products and wound care supplies.
Standard 3.3: Policies and procedures  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	FA	Infection control policies and procedures are documented. Staff are familiar with the policies and can describe best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training, and education of staff. The policies have been reviewed annually.

procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection prevention and control is included in the induction programme for new staff. Infection control education has been provided this year. Staff also receive one-on-one training as required.</p> <p>The infection control coordinator has completed on-line infection prevention training last in 2018. Information is provided to residents and visitors that is appropriate to their needs. Residents were also educated in the use of sanitisers and the importance of hand washing.</p>
Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>The clinical manager is responsible for the surveillance programme of infections. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the infection control meeting. When infections were sighted as occurring in files sampled, these were checked in surveillance data. All were recorded and data used to review outcomes both for the individual and the facility.</p> <p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infections. The use of antibiotics is also captured in the data. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and action plans to reduce the infection rates are discussed at monthly meetings. Overall infection rates are low. A suspected outbreak in December 2017 was well managed by the provider. The general practitioner and public health unit was notified and both monitored and provided advice as required.</p>

<p><b>Standard 2.1.1: Restraint minimisation</b> Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Craigweil House has policies and procedures around restraint minimisation and safe practice. Care staff interviewed state that there is a focus on minimising the use of restraint. There were three residents using restraints and one resident was using an enabler at the time of the audit. The restraints used are approved and identified in the policy.</p> <p>The facility has environmental restraint in place in the dementia unit with the unit being secure always. Staff and families are provided with the code for the keypads so that they can enter and exit the dementia unit.</p> <p>Staff receive annual training on restraint minimisation and safe practice. The healthcare assistants interviewed can describe the difference between a restraint and an enabler and can identify residents using a restraint or an enabler.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b> 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>A restraint approval process is in place. Restraint minimisation policies and procedures describe approved restraints including environmental restraint. The clinical manager is the designated restraint coordinator and they demonstrated good knowledge around restraints and ways to minimise injury to the residents. A signed job description was sighted.</p> <p>Consent for restraint is signed by the family member, the general practitioner, and the restraint coordinator. Files reviewed for residents using restraint confirmed that a consent was in place with this reviewed every six months.</p>
<p><b>Standard 2.2.2: Assessment</b> Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator in partnership with the family member/s and the general practitioner are responsible for assessing a resident's need for restraint. Restraint assessments are based on discussions with the resident and family and observations by staff. A restraint assessment tool is utilised when restraint is indicated (refer standards 1.3.4 and 1.3.5).</p> <p>A record for a resident using restraint was reviewed. An assessment for use of restraint was documented and this included the identification of any risks associated with the use of a restraint and the frequency of monitoring. Staff describe using other strategies and interventions prior to the approval of restraint. Restraint use is linked to the resident's long-term care plan.</p>
<b>Standard 2.2.3: Safe Restraint Use</b>	PA Low	<p>A current restraint register is in place. The register identifies any residents using a restraint (or enabler), and the type of restraint used. The restraint assessment reviewed identified that restraint</p>

Services use restraint safely		is being used for the safety of residents. The frequency of monitoring residents while on restraint is documented. An improvement is required regarding restraint monitoring and locks on bedroom doors in the dementia unit.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed six-monthly or as changes occur by the restraint coordinator. Restraint use is discussed in the staff meetings and during hand-overs. The family member, general practitioner, the restraint coordinator, and other staff are involved in the evaluation of the use of restraint including ongoing effectiveness. One family member interviewed confirmed that they were fully consulted in the use of restraint and had been involved in the evaluation of the use of restraint for their family member.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education is evaluated every six months. Evidence of review of policies and procedures, in the meeting minutes and in discussions with the restraint coordinator and staff confirmed ongoing discussion and review.  Staff interviewed could describe the use of restraint, the goal to minimise use of restraint and the risks of the restraint. Staff also reported that the training they receive on restraint minimisation and safe practice is adequate. Staff can describe use of restraint as per policy.

## Specific results for criterion where corrective actions are required

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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)
Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.	PA Moderate	<p>There are different perceptions around who is the ‘facility’ manager. This was discussed prior to and at the closing meeting by the management director and general manager at the opening and closing meetings with the explanation that the title of facility manager is not held at Craigweil House. There is a clinical manager, office manager and general manager. The site manager is the clinical manager with support with governance and oversight from the general manager who operates over three facilities. A change of manager notification form has been sent to the District Health Board.</p> <p>The clinical manager can describe their role as having clinical oversight as per the job description. The general manager states that the clinical manager is also the ‘facility’ or site manager however the clinical manager was not aware of this role. The previous facility manager is no longer in the service. The general</p>	<p>There is a lack of clarity around who holds the role of ‘facility’ manager.</p>	<p>Provide clarity around who holds the role of facility manager.</p> <p>90 days</p>

		manager identifies their role as being across three facilities with a role as 'facility manager' for the service. The general manager also states that they see the clinical manager as being also responsible for day-to-day operational management. The general practitioner, family, residents, and staff interviewed are not aware of who is identified as the 'facility' manager.		
Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Data is collected through monitoring of complaints, incidents, accidents, satisfaction surveys and internal audits. Satisfaction surveys are also completed as per the documented schedule. An internal audit schedule is implemented. The data is tabled at relevant meetings. Staff state that they are informed of data through relevant meetings. Staff and managers state that there is discussion of data at meetings however this is not documented sufficiently to confirm that there is analysis and discussion of data.	There is insufficient evidence in meetings minutes to confirm that quality related data is analysed, discussed and used to improve service delivery.	Document evidence of discussion and analysis of quality related data that is then used to improve service delivery.  90 days
Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented.	PA Low	There are meetings that are held monthly and these include the management; staff and registered nurse meetings. Other monthly meetings are not held monthly as expected and scheduled. These are the laundry; kitchen and activities meetings.	The laundry, kitchen and activities meetings are not held monthly as planned.	Review the frequency of meetings and implement the meeting schedule as planned.  180 days
Criterion 1.2.3.8  A corrective action plan addressing	PA Moderate	The internal audit schedule is implemented with corrective action plans documented at times when issues are identified. There is	Corrective action plans	Document corrective

<p>areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>		<p>insufficient evidence to confirm that corrective action plans are documented at all times when issues are identified through other means. The administration manager is responsible for completion of the internal audit schedule. This includes completion the audit, collating data and communicating results including those related to clinical audits such as the resident file audits. The clinical manager states that they do not have any role in the internal audit programme.</p> <p>The satisfaction survey completed in the past six months for example, identified that each of the five respondents had feedback that focused individually on a lack of communication, lack of care, staff not relaxed and staff overworked. While a report was completed with positive feedback, there was no indication that a corrective action plan had been documented to address the concerns raised. Meeting minutes did not always evidence resolution of issues when these were raised and residents wanted more resident meetings to provide opportunities for them to speak safely.</p>	<p>are not always documented when issues are raised and there is not always evidence of resolution of issues.</p> <p>The administration manager completes internal audits including clinically based audits including reporting of results to management but is not clinically trained.</p>	<p>action plans when issues are raised with evidence of resolution of issues including addressing of resident issues in a safe and appropriate manner.</p> <p>Provide opportunities for clinical staff to have input into the internal audit programme particularly when there are internal audits involving clinical care.</p> <p>90 days</p>
<p><b>Criterion 1.2.7.4</b></p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>An orientation programme is documented. This is generic and covers key aspects of the organisation and service delivery. The programme does not specify orientation for each level of care by describing the differences, management of specific residents and acuity of residents. There are nine staff currently completing or enrolled in the New Zealand Qualifications Authority training for dementia who work in the dementia unit and it is unclear if the orientation programme prior to the completion of this included</p>	<p>The orientation programme does not specifically differentiate between different levels of care</p>	<p>Document an orientation programme that includes orientation to different levels of care</p>

		training specific to that area. Staff state that they complete an orientation programme that includes reading of policies and procedures, working alongside a buddy in each area and on different shifts. Staff interviewed stated that the orientation is sufficient.	provided (rest home, hospital, dementia unit).	and support. 180 days
Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an annual training plan with training held monthly. Training records are maintained with staff signing to confirm attendance. Some sessions are well attended and others have lower attendance. A system to ensure that staff who cannot attend training is not always in place noting that some sessions are repeated to enable other staff to attend.	Documentation of attendance for training sessions at times shows that there is a low attendance and another system to support staff who cannot attend to access training is not in place.	Develop a process to provide training to staff who are unable to attend training offered and implement.  180 days
Criterion 1.2.9.7  Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.	PA Low	The resident records are locked in a secure place when not in use. There is a nurse's station that has a window looking out onto hallways. This provides opportunities for staff using the office to view what is happening in the hallways particularly for example, when handover occurs as observed during the audit. There is a whiteboard that informs staff of residents' care needs. This can be viewed from the hallway. When this was identified during the audit, the staff placed paper on the windows. This was not sufficient to block the whiteboard and was not considered a long-term solution as it then restricted the view of the hallways by staff in the nurses' station.	Information on a whiteboard in the nurses' station can be publicly observed.	Ensure that resident information is not publicly observable.  180 days

<p><b>Criterion 1.3.12.1</b></p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Controlled drugs are checked weekly by two staff as well as a six-monthly medication reconciliation completed by the pharmacist. The clinical manager identified discrepancies in the balance recorded for some liquid controlled medicine however actions have been put in place to address this. The controlled drug register records a correct balance for the drugs checked during the audit. Staff record any administration of controlled drugs and this automatically records the time date of administration. Staff record the date of administration in the controlled drug register, however at times, staff do not record the time of administration in the controlled drug register.</p> <p>The facility stores impress stocks such as antibiotics and other medications for residents in the hospital. There are no checks of the impress stock. There is no impress stock for residents in the dementia unit or in the rest home.</p>	<p>Time of administration of controlled drugs is not consistently documented in the controlled drug register.</p> <p>The impress system and stock is not checked at regular intervals.</p>	<p>Document the time of administration of controlled drugs in the controlled drug register.</p> <p>Check the impress system and stock.</p> <p>90 days</p>
<p><b>Criterion 1.3.4.2</b></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 Moderate</p>	<p>The interRAI assessment is completed on entry and at six monthly intervals. The interRAI assessment is being completed after the documentation of the care plan and therefore, the assessment is not used as the basis for service planning.</p> <p>The interRAI assessment identifies any resident losing weight. Nursing staff state that they do not monitor weight loss for residents as a group and are therefore not sure of numbers of residents losing weight. The clinical manager states that the service is currently putting a system in place to monitor weight loss. One file reviewed for a resident with weight loss did not evidence that the assessment was used as the basis of care planning (refer 1.3.6.1).</p>	<p>The interRAI assessment is not completed prior to the care plans being documented in all seven resident files reviewed.</p> <p>There is currently no system to identify key clinical issues particularly related to weight loss documented in</p>	<p>Complete the interRAI assessment prior to the care plan being documented and use as a basis for care planning.</p> <p>Use the assessment to inform the care planning for residents losing weight and develop and implement a</p>

			the interRAI assessment for a group of residents.	system to monitor residents as a group who are losing weight with evidence that service delivery is changed to meet resident needs.
Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Resident files sampled had long-term and short-term care plans. Care plans are developed using a newly introduced template. This does not provide individualised strategies and interventions to meet specific clinical needs as identified in the assessment (refer 1.3.4). One resident record for example, recorded a weight loss over a six-month period. The long-term care plan was not updated when weight loss was identified. The assessments in resident records reviewed identified specific individual resident needs such as management of frequent falls; skin conditions; continence issues and depression. The care plans did not individualise required support or interventions to meet the desired outcomes. There is no mention of the dietitian's report with a request for the non use of milk powder and the need to use full fat milk or the need for extra protein to be added to residents' meals as per specific individual need. As interventions had not been clearly documented, the cook was not able to fully follow specific needs for each resident. There were also incomplete documentation for one resident using a specific piece of equipment (refer to 1.3.3).	Care plans do not include specific individualised strategies and interventions to meet the needs of residents identified through the assessment process.  Specific interventions and documentation around the use of a specific piece of equipment for one resident	Ensure that care plans are individualised to meet needs identified in the assessment process.  Identify specific interventions for the use of CPAP to meet resident need and implement (note that this issue should be addressed as soon as

			was inadequate (a lack of monitoring /usage and outcome of use of this device) given the complexity of need for the resident.	possible). 30 days
Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Moderate	Short-term care plans are signed off when the issue is resolved. Long-term care plans are completed at the six-monthly timeframe with goals and interventions documented (refer standard 1.3.4). The service is now using a new format to align with the other two facilities owned by the same company and all previous care plans have been rewritten in to a new format when a new owner took over the facility in 2017. There is no evidence that the previous care plan has been evaluated in the majority of files sampled.	Not all files sampled provided evidence of a documented evaluation of the long-term care plan.	Evaluate each long-term prior to the new care plan being documented.  90 days
Criterion 1.4.4.1  Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuver with the assistance of their aid within their personal space/bed area.	PA Moderate	The hospital rooms have double doorways for beds and easy hoist access if required in most instances. There is room for mobility aides to be used safely in each resident's room. It was noted at audit that there were at least two residents (hospital level care) in rooms that required chairs, bed tables etc to be moved out into the corridor (in order to safely use a hoist), thus causing a hazard. Also individual lighting was provided in these rooms by use of a torch strapped to a wall in one instance and a touch battery operated light in another, both were hospital level residents.	Two rooms for residents requiring hospital level care are not suitable for cares to be provided given the complexity of need and acuity of the residents.	Review the needs and acuity of residents requiring hospital level of care to confirm that cares are able to provided safely and as per individual need.

				30 days
Criterion 1.4.6.3  Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Moderate	<p>The laundry has designated areas for dirty and clean laundry. On the day of audit, there was a box of clean linen (covered by plastic) placed in the dirty area. Staff in the area did not notice that this was in the incorrect area and the box stayed in the dirty area overnight despite staff being informed of the concern.</p> <p>There is adequate storage for all chemicals in locked designated areas however some communal or other areas have chemicals in them. These rooms are not locked when unattended. The cleaners trolley is left in the sluice room when the cleaner takes a break. This room was not locked on the day of the audit.</p>	<p>Areas identified as clean and dirty were not adhered to on the days of audit.</p> <p>Chemicals were sighted in rooms that were not locked on the days of audit including the sluice room, some bathrooms.</p>	<p>Provide training to staff to ensure that clean and dirty areas are used appropriately and monitor to ensure that this occurs.</p> <p>Ensure that chemicals are stored and safe secure areas when not in use.</p>
Criterion 2.2.3.2  Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation;	PA Low	<p>There are three residents using restraints (bedrail, chair with table and chair against the bed). The resident records reviewed indicate that frequency of monitoring the restraint is documented however there is little evidence that monitoring is completed as per the plan. Evidence of monitoring in one of the three records was only monitored sometimes i.e. once or twice per day as opposed to the planned hourly monitoring requirement documented in the care plan.</p> <p>Each bedroom in the dementia unit can be locked. The locks are disabled however the keys are kept in the nurse's station and therefore there is an ability potentially to lock bedroom doors. The unoccupied rooms in the dementia unit were locked by staff on the day of audit. Staff state that they never lock any occupied</p>	<p>Two out of three resident records did not evidence monitoring of use of restraint as per the care plan.</p> <p>There is an ability to lock bedrooms of residents in the</p>	<p>Ensure that staff monitor residents using restraints as stated in the care plan.</p> <p>Ensure that residents can freely access their own rooms at any</p>

(c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.		bedroom door in the dementia unit.	dementia unit.	time. 180 days
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## **Specific results for criterion where a continuous improvement has been recorded**

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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 audit.

No data to display

End of the report.