

# Nurse Maude Association - Nurse Maude Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Nurse Maude Association

**Premises audited:** Nurse Maude Hospital

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

**Dates of audit:** Start date: 1 October 2018 End date: 3 October 2018

**Proposed changes to current services (if any):** A new 75 bed hospital building on the same site is very near completion, with a move in date scheduled before the end of the year. A partial provisional audit is scheduled for early November.

During the audit, the service applied to the Ministry of Health and received approval to add hospital (non-acute medical) to the scope of their certified services. This was included in the audit.

**Total beds occupied across all premises included in the audit on the first day of the audit: 30**

# 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

Nurse Maude Hospital provides hospital (geriatric) and rest home care for up to 35 residents. During the audit, the service applied to the Ministry of Health and received approval to add hospital (non-acute medical) to the scope of their certified services. This was included in the audit.

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

There were no areas identified as requiring improvement. Residents and family members expressed a high level of satisfaction with the services provided. There is one area of continuous improvement related to good practice.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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The Health and Disability Commissioner's Code of Health and Disability Services' Consumers' Rights (the Code) is made available to residents. Content of the Code, consent processes and the availability of advocacy services are discussed at the time of admission and thereafter as required.

Personal choices, privacy, independence, individual needs and dignity of residents are respected. Staff were noted to be interacting with residents in a respectful manner. Nurse Maude is committed to respecting the individual values and beliefs of the residents.

Policies and processes are in place to enable those who identify as Māori to have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understand and implement related policies. Professional boundaries and good practices are being maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Family involvement is encouraged. Links with the community are maintained with access to community support organisations, volunteers and specialist health providers.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Strategic, business and quality plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the organisation and the hospital facility.

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

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

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Information about entry to the service is readily available. The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed.

A range of nursing and other clinical assessments, including the electronic interRAI assessment, are completed when a resident enters the service. Registered nurses are on duty 24 hours each day in the facility and are supported by hospital aides, allied health staff and a designated general practitioner. Shift handovers and communication sheets guide continuity of care.

Service delivery plans are entered into 'VCare', an electronic information management system. All plans viewed were individualised and comprehensive. They are based on an integrated range of clinical information from multiple sources. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified and reviewed on a regular basis. Family members and residents interviewed reported being well informed and

involved in care planning and evaluation. All stated the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities according to a Te Ora framework. A team of volunteers assist residents to participate in activities.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using an electronic system. Medications are administered by registered nurses and enrolled nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide safe food service delivery and staff have relevant food safety qualifications. The kitchen was well organised, clean and has an external registration confirming it meets industry standards. Residents verified satisfaction with meals.

## **Safe and appropriate environment**

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The facility meets the needs of residents and their families and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Call bells to summon assistance are in all resident areas. Security is maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

Nurse Maude has implemented policies and procedures that support the minimisation of restraint. There were no enablers in use at the time of audit. Staff were clear that enablers are voluntary for the safety of patients in response to individual requests. There was one resident using a restraint, which was the least restrictive option and used to keep the resident safe. A comprehensive assessment, approval and monitoring process with regular reviews occurring. Staff demonstrated a sound knowledge and understanding of the restraint process.

## 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 prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee and specialist infection

prevention and control advice can be accessed from the District Health Board; the local public health unit and laboratory consultants. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken. Related data is analysed, and any patterns or trends identified for quality improvement purposes. Follow-up action to assist with prevention and control practices is taken as and when required. Results are reported through all levels of the organisation.

## 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	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	Nurse Maude has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code and on advocacy services are included as part of the orientation process for all staff employed, as well as in ongoing training. This was verified in training records sighted and during staff interviews.
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	FA	Registered nurses and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and cover the various types of consent. These include competence to consent, Enduring Power of Attorney and decision-making processes, as well as for decisions around cardiac arrest/cardio-pulmonary resuscitation. A consent for Nurse Maude services, admission, treatment, care and support form is completed and filed on each resident's record at the time of admission. A Disclosure of Information form is also signed. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.  The service manager explained how advance care planning and the establishment and documentation of Enduring Power of Attorney requirements are encouraged. Copies of such documentation were found in residents' files reviewed. Processes for residents unable to consent are defined and documented where relevant

consent.		<p>in resident's records. Staff demonstrated their understanding, by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the nationwide Advocacy Service. The information pack provided to a resident at the time of their admission includes additional information on use of an advocate. Posters related to the Advocacy Service were displayed in the facility, and additional brochures were available at reception. Family members and residents interviewed were aware of the Advocacy Service and knew of their right to have support persons whenever they wanted or needed one.</p> <p>Staff interviewed were aware of how to access the nationwide Advocacy Service. The clinical nurse manager and service manager have an open-door policy. Neither could recall any time since the last audit when the advocacy service had been accessed but stated that residents and family are advised of this option whenever a complaint is made. Family members regularly advocate on behalf of residents and examples of these were discussed with the service manager.</p>
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	<p>Staff prepare residents for outings on time and show an interest in residents' families. The large and diverse group of volunteers, including school children, enhance community links. Community services such as the Stroke Foundation, the Parkinson's Society and the Cancer Society are being accessed, as are specialist health services for additional support when indicated.</p> <p>Residents are assisted to maintain links with their family. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected,	FA	<p>The complaints policy and procedure meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Suggestion, Compliments and Complaints Forms were visible around the facility to provide an alternative way for feedback. Residents and family members reported that the clinical nurse manager (CNM) and/or quality facilitator are always available to discuss any concerns.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The 2017</p>

and upheld.		<p>resident/family satisfaction survey identified that complaints resolution was an area that could be improved, and a corrective action process has been put in place to do so. The quality coordinator is responsible for complaints management and follow up, with support from the hospital quality facilitator and clinical nurse manager. Any complaints are reported through to the clinical governance group and quality and risk sub-committee of the board via a comprehensive quarterly quality and risk report. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit for the hospital service.</p>
<p><b>Standard 1.1.2:</b> <b>Consumer Rights During Service Delivery</b> <b>Consumers are informed of their rights.</b></p>	FA	<p>Most residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) when they were admitted. Copies of the Code and associated information is included in the information package at the time of admission. Family members also confirmed that such information was provided at the time of admission. The service manager informed that translations of the Code into other languages, or copies in other formats, can be made available, although this is seldom required.</p> <p>The Code is displayed in both the upstairs and downstairs sections of the hospital together with information on advocacy services. Details about how to make a complaint and copies of feedback forms are available at the front desk and through any manager or staff person.</p>
<p><b>Standard 1.1.3:</b> <b>Independence, Personal Privacy, Dignity, And Respect</b> <b>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</b></p>	FA	<p>Policies and procedures include one on confidentiality and privacy and details how the Privacy Code will be adhered to. Residents and families confirmed that they are receiving services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Nurse Maude documentation also states that clients receive services in a manner that recognises their values and beliefs.</p> <p>Staff understood the need to maintain residents' privacy and were observed doing so throughout the audit by shutting doors when assisting residents or taking residents back to their room. Likewise, staff were heard to be giving residents choices during day to day management.</p> <p>Residents' service delivery plans detail abilities and personalised strategies in which they can be assisted to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's family violence policy on abuse and neglect, that has a framework to identify and manage family violence. They also know what to do should there be any signs of abuse or neglect, as policies also describe the different types of abuse. The managers were familiar with the role of Aged Concern in supporting organisations with reported incidents of abuse or neglect, should the need arise. Education on abuse</p>

		and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.
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>The organisation demonstrates a strong focus on meeting the needs of Māori people. A Kaumātua and a Kaiāwhina maintain close links with the Kaihatu Māori (Māori advisor) who is now a member of the senior management team. A Nurse Maude strategic overview notes the organisation honours the Te Tiriti o Waitangi and reinforces respect for tangata whenua. There is a 2016-2018 Māori Health Action Plan based on the national Māori Health Strategy that describes the organisation's commitment to addressing special health needs of those who identify as Māori; defines a bi-cultural model of care and includes a set of objectives and planned actions with key indicators. A document titled 'Tikanga – Guidelines when working with Māori' was viewed and provides guidance to staff. An organisation-wide Neehi Maude Komiti Māori (Māori committee) is open to all staff who identify as Māori and they work together to advise on Māori related matters.</p> <p>Although around 400 clients who use Nurse Maude services identify as Māori, only one person in the hospital services is recorded as being of Māori ethnicity. This person has confirmed that they do not wish to identify as Māori. The resident and a family member, who is affiliated to local Māori cultural services, have both confirmed that a Māori framework is not required for the resident's service delivery / care plan. Staff work closely with this person's whānau.</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>A cultural safety policy was sighted and, not only defines culture in a broad sense, but notes it is not restricted to age, generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief and disability. In addition to the Māori Health Plan, there is a separate Pacific Health Plan. Recording ethnicity data is now a compulsory field in the electronic resident information management system, which is reportedly helping residents' culture and values to be respected. Staff informed the auditor during interview that cultural safety training is part of orientation and of ongoing mandatory training.</p> <p>Care plans reviewed clearly identified what ethnicity each resident identifies with and what their wider cultural needs are. Staff confirmed they are aware of the needs of one person who is a devout Catholic and the things that enable the person to feel safe. Chinese speaking staff have reportedly enhanced resident care, especially when a person has received end of life care. Examples of these were also evident in interRAI outcomes. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and results confirmed that individual needs are being met. Residents verified during interviews that they were consulted on their individual culture, values and beliefs and all stated that all their needs are being fulfilled. The activity coordinator described the pastoral care available and provided examples of how staff have acknowledged individual's spiritual needs.</p>

Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. No examples of these behaviours were evident in the incident reporting system.</p> <p>The generic, organisation-wide induction process for new staff includes education related to professional boundaries and expected behaviours. These professional boundaries and expected behaviours are written into all position descriptions and staff sign a Code of Conduct. Copies of these were sighted in staff files. Staff are required to follow organisational policies and procedures, which guide professional practices.</p>
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	CI	<p>Organisational policies and procedures reviewed for stage one audit support good practice. Input from a diverse range of internal and external specialists included for example: the hospice/palliative care team and on-site hospice specialists, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, seating specialists, psychogeriatrician and mental health services for older persons. The general practitioner (GP) confirmed the nurses seek prompt and appropriate medical intervention when required and are responsive to medical requests.</p> <p>Staff informed they receive management support for external education and access their own professional networks such as infection control webinars, palliative nursing care team and New Zealand Nurses' Organisation to support contemporary good practice. Of note, is that 70% of registered nurses either have or are studying for relevant post-graduate qualifications.</p> <p>A rating of continuous improvement has been allocated for this standard, as best practice was also evident in quality improvement initiatives in the hospital. These were specific to aspects of service delivery and some have resulted in external recognition, including publication of the results for one. A summary of the achievements for residents is trending down in the number of residents' falls; a decrease in the number of skin tears; improved wound care documentation; a significant reduction in the use of restraints; a reduction in the number of falls related to challenging behaviours and changed perspectives on care planning, with them now being based on residents' needs, rather than management of the presenting problem.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and	FA	Residents stated they are kept well informed about any changes that occur and family members confirmed they are updated about their relative's status when relevant. They are advised in a timely manner about any incidents such as falls and skin tears as well as outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed in VCare. There was also evidence of resident/family input into the care planning, and care plan review processes. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The service manager advised that although there was no

provide an environment conducive to effective communication.		<p>recent example available, when open disclosure is required, the first next of kin identified in the resident's record is advised at the most appropriate opportunity after the event and the time and date recorded.</p> <p>According to policy documentation, interpreter services are accessible via the DHB should these be required. The service manager and clinical nurse manager knew how to access them, although reported this had not been required for several years. Family members have assisted with translation of information for residents, or staff have been used as and when needed for residents for whom English was not their first language. There are not currently any residents who are not able to communicate in English, however the managers described several creative ideas that had previously been used to assist with communication.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Nurse Maude Strategic Overview 2016-2020 defines the vision, mission, values and scope of the services, as does the Quality Plan. Each of the four major services have an integrated service, quality and health &amp; safety plan. The Nurse Maude Hospital Integrated Service Action Plan 2017-2020 reviewed included goals, a service description, performance measures and indicators and progress reporting. Plans are reviewed annually. Nurse Maude has also adopted the Baldrige excellence model with a set of key performance areas which are the drivers of business success in the medium to long term. These are customer focus, motivated staff, high quality but affordable services, business development and growth, financial viability, leadership and direction. Progress in these areas forms part of the reporting process.</p> <p>A sample of three reports to the board of directors showed adequate information to monitor performance is reported including financial performance, health and safety and a clinical quality and risk update, including emerging risks and issues. Two members of the board interviewed felt well informed about the service and that they were advised of risks in a timely manner.</p> <p>Nurse Maude is managed by an experienced chief executive officer (CEO) who holds relevant qualifications and has many years' experience in the health sector. The hospital clinical nurse manager reports to the service manager for the hospital service, both of whom are well qualified and experienced for their roles. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The managers interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through the many community and professional group memberships.</p> <p>The service holds contracts with the Canterbury District Health Board for both rest home and hospital level care. At the time of audit all 30 residents were receiving hospital level care (two of whom were respite). Within the ARRC agreement are contracts for Support Care: Severe Medical Illness (SMI) and End of Life (EoL) care.</p>
Standard 1.2.2: Service Management	FA	<p>The chief executive is supported by a senior management team of six. There have been changes to the structure over the past year with the departure of the director of nursing. Options to ensure strong nursing leadership in the</p>

<p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>future are being explored with various aspects of the role distributed among the team, at this stage. The organisational structure reviewed defines lines of reporting and all staff spoken with were clear about roles and responsibilities. When the CEO or any member of the senior management team (SMT) are absent, responsibilities are delegated to another member, with email notification to all staff affected. Staff reported the current arrangements work well.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This is driven from the Nurse Maude Strategic Plan, the Nurse Maude Quality Plan and each service level plan. Dimensions of quality have been defined and the organisation uses a quality improvement methodology framework, including the 'Plan- do – check – act' process. Each service has a quality improvement register, with nine projects noted on the hospital register covering major and minor projects (eg, the introduction of the 'Vcare' electronic health record, wound care management, falls prevention and implementation of the Te Ara Whakapiri end of life care plan). Refer also criterion 1.1.8.1.</p> <p>Quality improvement is a standard agenda item at the service quality meetings, the clinical governance group (the function of which is currently under review), and the board quality &amp; risk sub-committee as confirmed in the sample of meeting minutes reviewed. A comprehensive quality and risk quarterly report includes analysis and trending of data related to incidents, falls, skin tears, complaints and compliments, projects, audit activity, restraint, infections and resident survey results. Relevant corrective actions are developed and implemented to address any shortfalls. Quality improvement initiatives and corrective actions are tracked on registers, available for all staff to view.</p> <p>Staff reported their involvement in quality and risk management activities through projects, audit activities and as part of their professional development and recognition programme (PDRP) activities and requirements. Resident and family satisfaction surveys have been completed showing a high level of satisfaction, with an opportunity for improvement identified and actioned to improve complaints resolution (refer also standard 1.1.13).</p> <p>Policies reviewed cover all necessary aspects of the service, including those suitable for the provision of medical (non-acute) services. The electronic data base 'SharePoint' is used to access policies, allowing for an easy search function. Policies are based on best practice and, with a few exceptions, were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The senior human resources (HR) advisor manages the health and safety programme for the organisation and described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. She is familiar with the Health and Safety at Work Act (2015) and works with the health and</p>

		safety committee and the SMT to support a safe environment. The board is aware of their responsibilities in this area. The health and safety risk register reviewed was comprehensive and current. The general organisational wide risk register was also reviewed and discussed with the quality coordinator who oversees this. This identifies 83 risks across the organisation, including service specific risks. These are analysed, rated, mitigation strategies developed, reviewed and reported to various levels of the organisation based on the level of risk. An example of a risk 'red flag' was noted in one of the meeting minutes/reports to the board.
Standard 1.2.4: Adverse Event Reporting  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.	FA	Staff document adverse and near miss events on an accident/incident form which is part of the 'Assura' electronic reporting system. All incidents are rated according to the national severity assessment code (SAC) rating system. Staff interviewed reported this is easy to use and a sample of four incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the hospital quality meeting. Key performance indicators (KPIs) have been set and incident numbers measured against these. Trends are identified. The monthly quality reports and meeting minutes are displayed on a specific quality notice board in the clinical areas, as sighted. An example of a planned corrective action process as a result of a negative trend in medication errors was discussed and has led to reduction in errors over a 12-month period, with ongoing close monitoring occurring.  The quality coordinator described essential notification reporting requirements. They advised there has been one notification of a power outage (during the 2017 Port Hills fire event) made to the Ministry of Health. There have been no notifications specific to the hospital setting.
Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruiting manager initiates the 'creating a job vacancy' and Approval to Appoint (ATA) process through the electronic recruitment system 'Snaphire'. The recruitment process includes referee checks, a Ministry of Justice check, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The current staff have the skills and knowledge to provide medical (non-acute) services, with access to specialist advice available.  There is also a large volunteer workforce and the manager of the volunteers interviewed was able to demonstrate the employment process which follows the same lines as for paid staff and meets good practice requirements. The records of a new volunteer working through the employment process on the day of the audit were reviewed with the manager and demonstrated a robust and comprehensive process, including referee checking. Volunteers are used in the hospital service to support the activities staff/programme and provide one-on-one activities (eg, reading the paper to a resident).  Staff and volunteer orientation includes all necessary components relevant to the role. The orientation process is

		<p>both organisation wide and role/service specific and includes a ‘buddy’ process. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation. Volunteers complete a programme appropriate to their specific role, including infection prevention and control and health and safety components.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The calendar for 2018 was reviewed and discussed with the CNM, who is in the process of developing the 2019 programme. Education is overseen by the CNM with the support of the part-time educator. Most training is provided via ‘e-learning’ using Moodle and HealthLearn. Records are kept on both the PayGlobal electronic system and by the educator on a spreadsheet and showed that all requirements have been met or are in progress. The service manager discussed the annual performance appraisal process which meets requirements, and which identified training opportunities and professional development goals. Staff interviewed felt very well supported by the organisation in this area. There are nine RNs who are trained and competent in the interRAI assessment process.</p>
Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). There is a mix of RNs, ENs and hospital aides on morning and afternoon shifts and a minimum of one RN and two hospital aides on each night. The hospital service is spread across two floors. Staff interviewed reported that, although they are allocated to one floor, both areas work together as a team and staff will move between the floors to support the needs of residents at any given time. The service can adjust staffing levels to meet the changing needs of residents and the clinical nurse manager (CNM) described the use of the hospital casual pool to support any increase in demand or unplanned leave. InterRAI acuity data is reviewed but found to be of limited use in relation to staffing decisions. No changes will be required to accommodate medical (non-acute) services. Access to expertise from within other Nurse Maude Services and external specialist health professionals is available and used, as and when required. The service manager and CNM share on call responsibilities. There is also access to a duty manager with roles and responsibilities defined. Staff reported there were adequate staff available and this was supported by the residents and family members interviewed. Observations and review of a roster cycle confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and/or CPR training.</p>
Standard 1.2.9: Consumer Information Management Systems  Consumer information	FA	<p>The resident’s name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled.</p> <p>Both hard copy and electronic systems were in place, with the electronic (VCare) system increasingly being used</p>

<p>is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>as more staff become trained in its intricacies. In both systems, all clinical notes reviewed were current and integrated with GP and allied health service provider notes. InterRAI assessment information is being entered into the Momentum electronic database and manually transferred across to the VCare electronic system. Summary interRAI documents are printed off and filed in the hard copy records. Residents' clinical records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely and are readily retrievable using a cataloguing system. They initially remain on site in a locked room upstairs, until transferred across to a secure off-site document storage system approximately one year later. Residents' files are reportedly held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit. Current files were in padlocked units with keys held by key personnel.</p>
<p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Referral processes from local hospitals and a range of health services and health professionals are the main ways in which new residents enter the Nurse Maude hospital, although families and prospective residents may make initial enquiries at any time. Entry to the service may commence once the person's required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with either the service manager, or the clinical nurse manager. Any person making an enquiry about the service provider, or who has been transferred into the service, is provided with written information about the service and the admission process. At times, the service operates a waiting list for entry, otherwise residents may enter direct from the local public hospitals when there is a vacancy. The organisation seeks additional information from the health system including GP practices for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. All said the process had been straight forward and that all questions had been satisfactorily answered. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with either a family member or staff person acting as an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family.</p> <p>At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. An example reviewed of a patient recently transferred to and from another facility showed relevant documentation was made available and open communication</p>

		<p>processes had occurred. Likewise, relevant documentation had been made available for a person (the tracer) who had had several admissions to acute local hospital services over recent months. Family of the resident reported being kept well informed during the transfers of their relative.</p> <p>All referrals are documented in the progress notes with a copy of the referral form held on file.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is comprehensive, current and identifies all aspects of medicine management in line with legislation and the Medicines Care Guide for Residential Aged Care.</p> <p>Safe medicine management via the use of an electronic system, was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Only registered and enrolled nurses administer medications, and all have completed an annual medicine management competency that includes specialty areas of management of diabetes, warfarin and syringe drivers, for example.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by two registered nurses against the prescription. All medications sighted were within current use by dates. A clinical pharmacist visits the hospice daily and is available to respond to hospital staff enquiries when required.</p> <p>Controlled drugs are stored securely in accordance with requirements and are checked by two staff for accuracy in administration. An internal review that had resulted in additional monitoring of documentation for controlled drugs was sighted and confirmed improvements. The review had been initiated in response to less than optimum internal audit results.</p> <p>Records of daily temperature checks for the medicine fridge and the medication room were within the recommended range.</p> <p>Good prescribing practices were evident within the electronic system and demonstrated key requirements of dates, identity of the prescriber, at least three-monthly reviews, evidence of discontinuation of medicines and all requirements for pro re nata (PRN) medicines met.</p> <p>There are not currently any residents who self-administer medicines at the time of audit, although safe systems are in place should this be required.</p> <p>Medication errors are reported through Assura, the electronic adverse event reporting system. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Neither standing orders nor verbal orders are used at this facility as the GP prescribes through the electronic system.</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 delivery.	FA	<p>Food services are provided on site by an external contractor and team of kitchen assistants and is in line with recognised nutritional guidelines for older people. The four-week rotating menu follows summer and winter patterns, meets the nutritional guidelines for older people. The kitchen manager advised that the menus are reviewed annually by a qualified dietitian employed by the kitchen contractor and evidence of the annual review of the summer menu was sighted. According to the kitchen manager, she liaises with the dietitian to have items replaced with others of similar nutritional value whenever menu items are not consistent with the preferences and needs of the residents.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed and a team of volunteers are scheduled to provide additional assistance.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries that has an expiry date of 7 April 2019. In addition, the contractor has industry registrations of ISO9001, ISO14001 and ACC WSMP Tertiary through Telarc. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing ongoing relevant food handling training.</p>
Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria, or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The service manager advised she will provide advice and direction to assist people for whom Nurse Maude will not be the best service provider to meet their requirements.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, the manager advised that a referral for reassessment to the NASC would be made and in consultation with the resident and whānau/family, a new placement found. No examples of this occurring could be recalled. However, an example of a person returning to Nurse Maude on the day of audit, after a week in another facility, was discussed with the</p>

organisation, where appropriate.		<p>service manager. The person's records were reviewed, and the family interviewed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p><b>Standard 1.3.4: Assessment</b>   <b>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</b></p>	FA	<p>An initial nursing assessment is completed on entry to the service for each resident. More specific information is documented as indicated, using validated nursing assessment tools such as Abbey pain scale, falls risk, Braden scale for skin integrity, nutritional screening and depression scale. All such assessments identify shortfalls, deficits and any resident's needs to inform care planning.</p> <p>The sample of care plans reviewed also had an integrated range of resident-related information obtained from needs assessors, other health professionals, hospital admissions, family interviews and the resident themselves, when possible. A printed list extracted from the electronic system confirmed all residents have current interRAI assessments completed by one of nine trained InterRAI assessors on site.</p> <p>The diversional therapist completes a personal, social profile for each new resident within the first three days of admission and this information contributes to the development of their activity plan. A physiotherapist visits once a week and undertakes an assessment of the mobility, equipment and manual handling needs of each new resident. A physiotherapy assistant, who works five days a week, follows through on the physiotherapist's recommendations.</p>
<p><b>Standard 1.3.5: Planning</b>   <b>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</b></p>	FA	<p>Residents' service plans are documented electronically within the VCare system. The goals and comprehensive action plans demonstrated follow-through from the outcomes of the integrated assessment process and other relevant clinical information available. Likewise, the care plans reviewed reflected the needs identified by the interRAI assessments and re-assessments. Registered nurses are responsible for development of the service delivery plans and for ensuring the hospital aides implement them as documented.</p> <p>The service delivery plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. All residents' files reviewed were comprehensive and addressed the holistic needs of the relevant residents. Any change in care required was documented and reported to be verbally passed on to relevant staff. Short term care plans were in place for conditions that the service manager described as being out of the usual and included infections, wounds and broken skin integrity.</p> <p>Residents and families reported consultation and participation in the development and ongoing evaluation of care plans.</p>

<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. Family members/whānau repeatedly expressed gratitude for the high level of care provided, the professionalism of staff and the efforts made to meet residents' needs. Residents reiterated these comments and noted that staff listen to them and give them options.</p> <p>The attention to meeting the diverse range of each resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is, overall, of a high standard. Care staff confirmed that care was provided as outlined in the documentation and expressed pride in working for this service provider. A range of equipment and resources suited to the level of care being provided, and in accordance with individual resident's needs, was available.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is coordinated by a trained diversional therapist who holds a national Certificate in Diversional Therapy. Two volunteers are rostered for each morning and two for the afternoon, to assist with implementation of the programme. Efforts are made to cover weekend days; however, this is not always possible. The diversional therapist informed she can request additional volunteers from the volunteer coordinator for special events when this is required.</p> <p>A personal profile that includes a social, occupational, spiritual, cultural, physical and intellectual assessment and history is completed for each resident on admission. The information obtained is used to ascertain the resident's needs, interests, abilities and social requirements and contributes to the planning of the weekly activity programme. Te Ora (Therapeutic Everyday Occupational Recreational Activities) is the framework used for the overall activity programme provided. The level of each person's participation in the activity programme is monitored and evaluation of the personal activity goals is undertaken approximately six-monthly. Changes are currently underway to align the review of activity goals with the six-monthly evaluation of the formal six-monthly care plan review using VCare.</p> <p>Copies of activity plans that were sighted matched skills, likes, dislikes and interests identified in summarised assessment data. Planned activities reflect the Te Ora framework and although there are few outings, the programme is varied and reflects ordinary patterns of life. Individual, group activities and regular events within the facility are organised. Interdenominational prayer and hymn services are organised weekly. Volunteers are actively involved and reportedly make significant contributions. Examples of activities in the programme included live entertainment, newspaper reading, baking, craft, games, quizzes, happy hour and seasonal celebrations.</p> <p>Mixed opinions about the activity programme were provided during staff, resident and family interviews with some saying there was a good range of interesting and varied activities and others using the words 'sometimes good', 'some appear bored' or 'suppose it is okay'. However, resident and family satisfaction surveys demonstrated satisfaction with the programme. The activities programme is discussed at the monthly residents' meetings.</p>

		Minutes showed that residents' input is sought and responded to. Comments about the programme were generally favourable and new suggestions had been offered and followed through when possible.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. Progress notes are still hard copy and those sighted were comprehensive and informative. Registered nurses coordinate handovers at shift changes and manage any changes in a resident's condition.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. These are now being undertaken electronically. All evaluations are documented by a registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. In the care plans reviewed, there were multiple examples sighted of documented changes in response to a person(s) condition changing.</p> <p>Examples of short-term care plans, which are also recorded electronically, demonstrated these are being consistently reviewed according to the level of clinical indication and the degree of clinical risk. Most reviews are occurring every one to two days. Wound management care plans are being reviewed according to the individual treatment plans with evaluations occurring when dressings are changed. According to resident and family members interviewed, staff provide ongoing informal updates on progress. Multi-disciplinary reviews that involve family members and wider allied health teams are undertaken when a person's condition has changed significantly, or annually. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress.</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 providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or a registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to stoma services, wound care specialists, palliative care team, allied health services and specialist consultants for example, as well as to organisations such as the Stroke Foundation and Alzheimer's New Zealand.</p> <p>Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

<p><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>Staff follow documented processes for the management of waste and infectious and hazardous substances, including cytotoxic drugs. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment, with staff observed using this.</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>A current building warrant of fitness (expiry date 1 January 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and adequately maintained. The environment is appropriate for residents, with comfortable furniture and areas for families and visitors on both floors. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as was confirmed in documentation reviewed, interviews with the quality facilitator and quality coordinator and observation of the environment/equipment. There is documentation displayed in staff areas relating to emergency contacts for any specific urgent maintenance/repairs.</p> <p>External areas for residents are currently limited due to the building of the new hospital on the same site. This is very near completion and incorporates external areas for residents. In the interim, residents do have access to the outside area near the hospice which provides a safe environment for residents and families with some children's play equipment available.</p> <p>Residents and families confirmed they were happy with the environment.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Rooms have either their own ensuite or share a bathroom between two or three rooms. There are appropriate locking devices for privacy. All have secured and approved handrails and other equipment/accessories available to promote independence and privacy.</p>

when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All rooms are of an adequate size. Items to personalise each resident's room were evident. There are areas to store equipment and walking aides.
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	On both floors of the hospital area, communal areas are available for residents and families to engage in activities. Privacy can be maintained. There are dining areas set up to support a home like environment. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services	FA	The manager of the kitchen service has recently taken over the management of both the laundry and cleaning services. This is an externally contracted service. The onsite laundry was visited, and processes discussed with the manager who outlined several recent improvements. Regular audits of the laundry occur with an annual audit by the infection prevention and control service. Filters in the dryers are changed daily. The area was clean and well organised. Handwashing facilities are well located.  Chemical storage has recently been reviewed and now all chemicals are stored in one location with new cleaning trolleys safely stored in clinical areas. Chemicals in sluice rooms were labelled and stored safely. Cleaning

<p>appropriate to the setting in which the service is being provided.</p>		<p>chemicals for any machines are supplied by an externally contracted service using a closed system. Cleaners are allocated hours and areas to clean and cleaning audits occur regularly. The infection prevention and control manual described chemicals to be used to clean each item/area. There have been some recent changes to cleaning schedule practices to improve services. All clinical areas visited were clean during the audit.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b>             Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and were known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire, earthquake or other emergency. Nurse Maude took part in a recent emergency operations centre exercise practised as part of a regional exercise. The SMT, service managers, quality team and personal assistants completed CIMS (Coordinated Incident Management Systems) training in August 2018. The current fire evacuation plan for the hospital area was approved by the New Zealand Fire Service on the 27 February 2008. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 1 May 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. A power outage during the fires on the Port Hills (February 2017) demonstrated effective systems were in place.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets and mobile phones, were sighted and meet the requirements for the number of residents. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting and systems are regularly tested. There are also first aid boxes available and easily accessible.</p> <p>Call bells alert staff to residents requiring assistance. There were no concerns raised in relation to the time taken to respond to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and security lighting is in place, as are CCTV cameras in front entrances and common spaces. Residents, staff and families are made aware of these. There is swipe card access to staff only areas. There have been no breaches of security to the building reported.</p>
<p><b>Standard 1.4.8: Natural Light, Ventilation, And Heating</b>             Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>Heating and cooling systems via heat pumps are available. All rooms have good light and ventilation. There is a specific external smoking area that is safe and meets legislative requirements. There have been no complaints related to heating or ventilation. Areas were at a comfortable temperature and well ventilated during the audit.</p>

<p>environment that is maintained at a safe and comfortable temperature.</p>		
<p><b>Standard 3.1: Infection control management</b>   There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual. This has been developed at organisational level, with input from infection prevention specialists. The infection control programme and manual are reviewed annually.</p> <p>An infection control nurse provides advice and support to all Nurse Maude services, including the hospital. The role and responsibilities are defined in a position description and include responsibility for updating policies and procedures, responding to infection related enquiries, outbreak management and infection surveillance. The infection control nurse coordinates an organisation wide infection control committee. She works closely with the quality managers, provides them with monthly infection surveillance reports and assists them with internal audits for the environment, hand hygiene and spot audits, especially cleaning. A quarterly infection control report is provided to the quality and risk sub-committee of the board and there was evidence of infection control discussion within a set of clinical governance group meeting minutes.</p> <p>Signage at the main entrance to the facility requests anyone who is unwell, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p><b>Standard 3.2: Implementing the infection control programme</b>   There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control nurse has appropriate skills, knowledge and qualifications for the role. Training records verified that she has undertaken a post graduate certificate in infection prevention and control, attended relevant study days and attends, and is involved in, annual infection prevention conferences. She has skills as a hand hygiene auditor and a vaccinator. There is access to suitable local networks, including the GP, infection control teams at the local public hospitals and the local public health unit. Expert advice from the community laboratory is available if additional support/information is required.</p> <p>The infection control nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. She confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>A Nurse Maude infection control committee is led by the infection prevention and control nurse. The committee meets 11 times a year and has 13 members who are representatives for the various areas of practice throughout the organisation.</p>

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 procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	<p>The infection prevention and control manual contains policies and procedures that reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in December 2017, includes appropriate referencing and are 'living' documents with ongoing reviews and updates made as the content changes.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Volunteers also attend a slot on infection prevention and control during their orientation. Staff interviewed talked of the five moments of hand hygiene, reported training involving infection prevention and control scenarios and quizzes. Infection control training topics may be of an 'on demand' nature in response to events within the service, or the wider community. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. The infection control nurse confirmed annual hand hygiene competencies are undertaken by each staff person. Staff can access infection prevention and control related Health Learn web based self-directed learning and may attend the orientation session more than once if they choose.</p> <p>Infection prevention and control education is provided by suitably qualified personnel, including the infection control nurse who has a slot in the generic orientation for new service providers and external infection prevention and control specialists, one of whom provides a special interest session once a year.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and explanations of requirements for managing antibiotic</p>

		resistant infections.
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>Policies and procedures detail surveillance processes, which are led by the infection control nurse. Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms; however, laboratory results are also checked when relevant. Infections reviewed include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies.</p> <p>When an infection is identified, a record of this is documented in the Assura electronic management system for incident reporting, with appropriate details for the resident entered into VCare. The infection control nurse follows up on all reported infections and collates the data generated from the infection reports. Monthly infection surveillance data is collated and analysed to identify possible causative factors and required actions. Results of the surveillance programme are summarised and shared with the infection prevention and control committee and the quality team, who assist by producing graphs and integrating the information into the wider organisational quality management system. The data analysis and graphs assist in identifying trends for the current year, and comparisons against previous years are made. The hospital benchmarks the occurrence of urinary tract infections against the threshold set by Standards New Zealand as an indicator for safe aged care.</p> <p>New infections and any required management plans recommended by the infection control nurse are discussed with staff at shift handovers, to ensure early intervention occurs. Infection surveillance results are then shared with staff as part of the quality report at the registered nurses' and general staff meetings. This was confirmed in meeting minutes sighted and during interviews with staff.</p>
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management across all services, including the hospital, and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>There was one resident using bedrails intermittently as a restraint. There were no enablers in use. Staff interviewed had a clear understanding of the difference between a restraint and an enabler and complete yearly education using an electronic on-line learning programme.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident in the one file reviewed and from interviews with staff.</p>
Standard 2.2.1: Restraint approval and	FA	Any restraint use is approved by the restraint coordinator, the GP and the family/EPOA. All matters relating to restraint, including approved restraints and restraint use are reported to the ethics committee (a sub-committee of

<p>processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>the board). The coordinator and staff interviewed were clear about lines of accountability, what restraints have been approved, and that the overall use of restraint is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file for the one resident using restraint. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator and the quality facilitator described the documented process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. The completed assessment was sighted in the record of the resident using bedrails. There is a comprehensive behaviour care plan for this person that identifies triggers and guidance to staff as to how to manage each trigger to prevent the use of the bedrails. Access to specialist services have been used as required (eg, the gerontology service, the occupational therapist and the GP).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds, and for the current resident using a restraint, a 'perimeter guard mattress') and proactive management of the resident's behaviour.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. The monitoring record of the one resident currently using occasional restraint, had the necessary details, including the length of time the bedrails were in use. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and regularly reviewed. The register was reviewed and contained the one resident using a restraint and one other resident who had used a lap belt restraint previously. This person has not used a restraint for over three months due to improved strategies and planning to manage</p>

		<p>any challenging behaviour. There was sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This has been a focus for the organisation (Refer also criterion 1.1.8.1). Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when it is in use.</p>
<p>Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint.</p>	FA	<p>Review of the resident's file of the person using a restraint showed that the use of restraint was reviewed and evaluated during care plan and interRAI reviews and three-monthly restraint evaluations. There was evidence in the file of family involvement in the evaluation process and satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>A six-monthly review of all restraint use, which includes all the requirements of this Standard, is completed with a report to the ethics committee. Reports are also discussed at quality and staff meetings, including analysis and evaluation of the amount and type of restraint used in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed from the January to June 2018 restraint report and interviews with the CNM and the quality facilitator confirmed that the use of restraint has been steadily reducing, including for the one person currently using bedrails. Over the past year the numbers of restraints in use have reduced from three residents to one, with both the hours and number of episodes reducing significantly.</p>

## **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.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Incident reporting and quality improvement processes have been improved with the use of electronic reporting and data collection processes. Electronic processes are enabling trending against key performance indicators to be more easily identified and relevant benchmarking against New Zealand indicators to occur. Two continuous quality improvement initiatives that have led to best practices are in relation to falls prevention and minimisation and wound care and resident injury. The improved reporting processes identified hospital residents' falls were exceeding the benchmark. Review processes resulted in recommendations for improvement that were subsequently implemented. There is now a trending down in the number of falls, which have reduced falls below the benchmark level, albeit the ongoing reviews show they are still not at the target set. Similarly, the incidence of resident skin tears rose over the first half of 2018. Quality improvement processes were implemented and included the improvement in wound care documentation and recording of outcomes. The incidence of skin tears is now trending down with the review concluding several	In addition to almost three quarters of registered nurses improving their practice by completing (or currently undertaking) post-graduate qualifications, several service delivery related continuous quality improvement initiatives have been implemented. These initiatives have resulted in a trending down in the number of falls; a decrease in the number of skin tears; improved wound care documentation; a significant reduction in the use of restraints; a reduction in the number of falls related to challenging behaviours and changed perspectives on care planning with residents' goals and actions now being based on need, rather

	<p>good practice processes have contributed to this change.</p> <p>A third initiative of note is in relation to an increase in incidents relating to challenging behaviours within hospital services. The VCare recording system was introduced and gave the organisation the opportunity to review how care planning was planned, implemented and achieved. This included appropriate identification of the underlying causes of behaviour that challenge and correctly identifying meaningful goals appropriate to the resident and their family/ whānau needs. Documentation of interventions that show how to reduce triggers causing behaviours that challenge is encouraged, rather than interventions that simply manage the behaviour. A range of monitoring and review processes of care plans and attitudes has been established. Results have demonstrated a significant reduction in the use of restraint, for two residents. In addition, care plans are reportedly showing a change in the type of problems/needs identified to show the underlying cause of behavioural incidents, thus allowing staff to focus on identifying distraction, or interventions to prevent the behaviours that challenge. An unanticipated result has been a reduction in the number of falls associated with challenging behaviours.</p> <p>Another area of good practice of note is that Nurse Maude Hospital supports all staff to attend education in addition to education defined as mandatory. As a result, 70% of registered nurses either have, or are studying for, relevant post graduate qualifications. This improves practice overall, gives a solid evidence-base to care provision, and ensures more staff have up to date knowledge.</p>	<p>than just their management.</p>
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End of the report.