

The Napier District Masonic Trust - Elmwood House and Hospital

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 Q-Audit 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:	The Napier District Masonic Trust
Premises audited:	Elmwood House and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 27 September 2018 End date: 28 September 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	36

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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

Elmwood House and Hospital provides hospital and secure dementia level care for up to 39 residents. The service is one of two owned by the Napier Masonic District Trust Board and is managed by a registered nurse with management and administration support from the organisation's main site in Taradale. Residents and families spoke positively about the care provided.

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

There is one area for improvement identified at this audit related to staff training records. A continuous improvement has been identified relating to the medication system.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. Independent advocacy is available.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a local dementia service network and a range of specialist health care providers to support best practice and meet resident's needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided is regular and effective. The service has been restructured over the last year and is now managed by an experienced and suitably qualified registered nurse. The nurse manager is supported by facility registered nurses and the organisation's quality and operations manager.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the particular needs of residents with dementia and the changing needs of all 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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The organisation works closely with the local Needs Assessment Service Co-ordination Service (NASC) to ensure access to the facility is appropriate and efficiently managed. Relevant information is provided to all prospective residents and family to facilitate the admission process.

Residents' needs are assessed within the required timeframes. Registered nurses are on duty 24 hours a day seven days a week in the facility and are supported by health care assistants and allied health staff meet the needs of the residents. A contracted general practitioner, contracted pharmacist, podiatrist and physiotherapist make up the multidisciplinary team at this facility. On call arrangements are in place. Shift handovers and communication sheets guide continuity of care and service delivery.

The lifestyle care plans are individualised and are based on a comprehensive and integrated range of clinical information. Short term care plans are developed and implemented to manage any new problems that occur. Resident's records are maintained to a high standard and care planning reviewed has personalised interventions to achieve goals/outcomes set. Residents and families

reported being kept well informed and involved in the care planning and evaluation process. Care provided is of a high standard. Referrals are made by the general practitioner as needed and appropriate handovers are provided if a resident is transferred to another health service.

The planned activities programme is implemented by an activities coordinator and the programme provides residents with a variety of group and individual activities and maintains their link with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures and are consistently implemented using an electronic system. Medications are administered by competent staff all of whom have been assessed as competent to do so.

The food service has a food safety plan and policies to guide food service delivery which is supported by staff with food safety training and qualifications. The nutritional needs of the residents are met with special needs being catered for. The kitchen is well managed, organised, clean and tidy and meets all food safety standards. Residents and family interviewed verified satisfaction with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The Elmwood facility consists of one building of two wings, one for hospital care and one for secure dementia care. Services are provided in a safe, secure environment that is appropriate to the needs of the residents. There are sufficient appropriate amenities, equipment and supplies to meet residents' needs and to facilitate independence.

Residents, visitors and staff are protected from harm from exposure to waste, infectious or hazardous substances generated during service delivery. Laundry and cleaning services are provided in-house.

Documentation identifies that all processes are maintained to meet the requirements of the building warrant of fitness. Planned and reactive maintenance is documented. The buildings, furniture and fittings are well maintained. Systems are in place for essential, emergency and security services, including a disaster and emergency management plan and emergency supplies.

All residents have access to a fully fenced, secure outdoor area with paved pathways and shaded areas. The design of the dementia unit and gardens provides safe wandering areas for residents with cognitive impairment.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and nine restraints are in use at the time of this audit. Assessment, approval and monitoring processes with regular reviews occurs. Staff interviewed have good knowledge and understood the restraint and enabler processes and that the use of enablers is voluntary for the safety of the residents in response to individual requests.

Infection prevention and control

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

Staff interviewed demonstrated a sound knowledge of infection control principles and practice. Infection control is guided by relevant policies and supported with sound education. Resources and reference information is readily available.

Aged care appropriate surveillance is undertaken, and results are reported, and information is fed back to staff. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	1	99	0	1	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

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The organisation 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 understood the requirements of the Code and were able to describe how they respected the resident's right during service delivery. Observation confirmed that their practice demonstrated respectful communication, encouraging independence, providing options, and maintaining dignity and privacy with residents. Training records verified that the Code is included as part of the orientation process for all staff employed and in ongoing training. Staff receive education on consumer rights legislation. This occurs during orientation and in ongoing education. In interview, staff were able to describe how they incorporated resident rights into their day to day practice. Residents and family members interviewed indicated that they are satisfied that the residents' rights are respected.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>Informed consent policies provide guidance to staff about informed consent. Advanced care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to give consent are defined and documented, as relevant, in the residents' records. Family members and competent residents interviewed indicated that they received full information and explanations about any decisions and choices related to their care. Residents with dementia participated in consent as far they are able. Nursing and care staff interviewed understood the principles and practice of informed consent. Clinical</p>

they need to make informed choices and give informed consent.		files sampled evidenced informed consent has been gained appropriately using the organisation's standard consent form. The enduring power of attorney (EPOA) documentation has been activated for all residents living in dementia house. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Family members interviewed reported that they are provided with information regarding access to advocacy services. Families are encouraged to involve themselves as advocates. Contact details for the Nationwide Health and Disability Advocacy Service are listed in the resident information booklet and pamphlets are available at reception. Education on advocacy and support is conducted as part of the in-service education programme.
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	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainments. The organisation has unrestricted visiting hours and encourages visits from residents' family and friends. Family members stated they felt welcome when they visited and comfortable in their dealings with staff. The organisation belongs to a local dementia network and participates in education with another provider.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy complies with Right 10 of the Code. Residents and their family are advised on entry to the facility of the complaint processes. The nurse manager is responsible for responding to and managing complaints. There have been four formal complaints since the last audit. These were sampled and confirmed that they had been managed in line with policy and legislation requirements. A complaints register is documented, and complaints are discussed at quality team meetings. Mandatory staff training includes the management of complaints. There have been no complaints to the Health and Disability Commissioner or the DHB since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information pack provided and in discussion with staff. The Code is displayed in Maori and English throughout the facility together with information on advocacy services, how to make a complaint and feedback forms. Family members interviewed were aware of the consumer's

their rights.		rights and confirmed that information was provided to them during the admission process.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Education on abuse and neglect was confirmed to occur during sampling of orientation and ongoing education records. The residents' personal privacy is maintained. All resident rooms are single. Staff were observed to knock before entering a resident's room. It was observed and confirmed in interviews with family members that support for personal cares is conducted in a respectful manner. Individual values and beliefs are documented in care plans. Residents are supported to maintain their independence with the residents able to come and go within the building and around the secure grounds as they are able. Residents are able to attend church or have their spiritual adviser attend them at the home. There are documented processes regarding abuse and neglect and all staff receive training. There were no reports of alleged abuse or neglect in the records sampled.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. Staff support residents in the service who identify as Māori to integrate the cultural values and beliefs that they choose. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on Tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents' files recorded their individual cultural needs. Family/next of kin input and involvement in service delivery/decision making is sought. Staff interviewed reported that they understand and have attended cultural training and demonstrated the importance of whanau for residents who identify as Maori. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. The Maori Health plan recognises the importance of whanau. A local kaumatua is available to provide the facility with advice and assistance when required, including blessings of rooms. All staff have undertaken cultural awareness and safety training.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and</p>	FA	<p>The resident files sampled identified the cultural and/or spiritual needs of the resident in consultation with the family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to provide guidance on delivery of individualised support in a culturally and/or spiritually sensitive manner.</p> <p>Residents and families reported that they were consulted about the resident's individual culture, values and beliefs and that staff respected these. Resident's individual personal preferences, required interventions and special needs were included in care plans sampled. The resident satisfaction survey confirmed that individual needs are being met. Staff interviewed reported on the need to respect individuals' culture and</p>

beliefs.		values. The families reported that cultural and religious beliefs are respected and reported. There is access to church services if requested. Individual birthdays and other events of individual importance are acknowledged and celebrated. Families are encouraged to participate in the social life of the resident.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The employment position description and the Code of Rights define residents' rights relating to discrimination or exploitation. Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education relating to professional boundaries, expected behaviours and the code of conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. Staff interviewed indicated that they would report any inappropriate behaviour to the facility manager. The facility manager reported that formal action would be taken as part of the disciplinary procedure if there was an employee breach of conduct. Family members confirmed that they felt their resident was safe and respected at all times.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The organisation encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals. For example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psych geriatrician and mental health services for older persons. The ongoing staff education programme covers the specific needs of residents with dementia and those needing hospital level care. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included the dementia service and garden being based on dementia friendly design principles.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to	FA	Residents and family interviewed confirmed that information is shared with them in an open manner. Advocacy and translation services are engaged as needed. Accident/incident reports included evidence of open disclosure. Family members interviewed stated they were kept informed of any health changes including accidents/incidents, infections and general practitioner (GP) visits. A family contact sheet is maintained in the residents' records and newsletters keep families informed of what is happening at the home. The service provides information and support for families about dementia care.

effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Napier District Masonic Trust (NDMT) commenced ownership and governance of Elmwood House and Hospital in 2014. The NDMT also owns and operates another facility in the Napier region and continues to combine the management system. The strategic management plan was approved in July 2018 and included goals, mission statement, values, vision and objectives defined in measurable terms. Board meeting minutes sampled confirmed that organisational performance is monitored through monthly reports from senior managers. The strategic plan includes the associated quality and risk management plan, service management plan, work health and safety plan and Maori health plan.</p> <p>The service was restructured in 2018. The positions of facility manager, clinical manager and clinical coordinator were disestablished. The facility is now managed by a nurse manager who reports to the NDMT Quality and Operations Manager (QOM). The nurse educator role is currently vacant. The organisational structure has been amended to reflect the changes in management and reporting lines.</p> <p>The Nurse Manager (NM) is a registered nurse with a current practising certificate with six years previous experience as a clinical coordinator in aged care. The NM is a full-time position and is supported by a 0.5 FTE assistant to the manager. The assistant is a senior health care assistant at the facility. There is evidence that the NM maintains the required training and attends regional meetings related to the management of an aged care facility.</p> <p>Elmwood House and Hospital is currently certified to provide 25 rest home dementia level beds and 14 hospital level beds. Twenty-two dementia level beds and 14 hospital level beds (one of which was a respite resident) were occupied on the day of the audit. The facility has contracts with the District Health Board for aged-related resident care (continuing care, dementia care), and for long term support – chronic health conditions (long term hospital and dementia care, short term day care, rest home and dementia care). The facility also has contracts for respite and day care services for rest home, hospital and dementia level care. Residents and family available were interviewed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and</p>	FA	<p>The NM is responsible for management of the Elmwood facility and provides leadership and clinical supervision to the team of registered nurses and health care assistants. The NM has maintained at least eight hours of professional development activities annually related to facility management and to her clinical role. Both the NM and the assistant have completed dementia care training. The QOM supports the NM, works across both sites and attends all quality meetings. The QOM takes over the facility management role in the absence of the NM, with support from the assistant to the NM and clinical support from the senior registered nurses.</p> <p>There is an experienced activities staff member who is currently undertaking study towards becoming a qualified diversional therapist who is responsible for oversight of the activities programme. A maintenance</p>

safe services to consumers.		staff member maintains the facility under the direction of the NMDT property and compliance manager. All support services are provided on site by facility staff. Clinical specialists and advisors are engaged as required.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a documented quality and risk management system. Relevant standards are identified and included in the policy and procedure manuals. These are accessible electronically (masters) and provided in hard copy to staff. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. There is a system for reviewing and updating quality related documents with evidence of ongoing reviews in records of quality meetings sampled.</p> <p>A quality and risk management plan is used to guide the quality programme and includes goals and objectives. A range of quality data is gathered and used to monitor and improve services. Internal audits and satisfaction surveys are conducted in a manner that reflects improvement principles. All quality related data is combined and discussed at quality team meetings. Corrective actions are developed and implemented to address issues. Improvement opportunities are noted and monitored for effectiveness.</p> <p>A quality improvement project to address medication errors in the dementia wing has been successfully implemented and sustained.</p> <p>Organisational risks are identified, and the Health and Safety Management Plan reflects current legislation. A health and safety representative has been designated and a committee has been established. The risk management plan covers the scope of the organisation. The organisation maintains tertiary level compliance with the Accident Compensation Corporation (ACC) partnership programme. A hazard identification and mitigation process is implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff through the monthly staff meetings. Data is used to identify issues and areas for improvements to services.</p> <p>The nurse manager described essential notification reporting requirements. They advised there have been no notifications of significant events made since the previous audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The selection and approval of new staff is the responsibility of the NM, with support from the QOM. Professional qualifications are validated during the recruitment process. Nurse practicing certificates are checked annually. A record of reference checks and police vetting is also maintained.</p> <p>All new staff receive an orientation to the organisation and an induction to their prospective duties. This includes the essential components of service delivery and the required competencies. When engaged, bureau staff are orientated prior to the commencement of their shift. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority. Improvement is required to ensure that orientation records specifically include the dementia wing and are consistently maintained in staff files. There is no documented process to identify and record the orientation of current staff when they move to a new role within the facility.</p> <p>The NDMT educator is currently vacant. The property and compliance manager is temporarily responsible for administration of the staff training system. The NM manages the clinical in-service education programme provided. Mandatory core education training days are held several times a year to make sure that all staff receive the training required by the ARRC contract. Staff working in the dementia unit have either completed or are in the process of completing the required dementia specific training. On-going competency assessments are current for medication management, restraint and first aid certificates. The nurse manager and one other RNs have completed the required interRAI assessment training and competencies. A data base is being developed to provide a more effective method for monitoring attendance at mandatory training.</p> <p>Staff performance is monitored annually. An appraisal schedule is in place and current staff appraisals were sighted in all staff files sampled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing rationale policy is based on 'SNZ: HB 8163:2005 Indicators for Safe Aged-care and Dementia-Care for Consumers'.</p> <p>In both the dementia unit and the hospital, the rosters evidence that sufficient cover is provided on all duties. Numbers and skill mix address the layout of the facility in two adjoining wings with the dementia wing being secured. The activities coordinator works across both the dementia house and the hospital. Group activities are encouraged in the dementia house on a daily basis and are planned to cover the 24 hour period. The activities provided in the hospital are more on a one to one basis but residents join in the group activities as able. Activities are provided by the activities coordinator or activities HCA five days a week.</p> <p>Registered nurses provide cover 24 hours a day, seven days a week in the hospital and the dementia wing. The dementia unit is staffed by a registered nurse (RN) every morning Monday to Friday with RN cover from the hospital at other times. RNs complete assessments, care plans and reviews. Sufficient health care assistants (HCAs) are allocated to the hospital and to the dementia wing to meet resident needs. HCAs</p>

		<p>interviewed reported that there are enough staff on duty and they were able to get through the work allocated to them.</p> <p>Additional staff are employed to maintain support services such as laundry, cleaning, activities, food services and maintenance. Families interviewed reported there are enough staff on duty to provide their relative with adequate care. Shifts are replaced in the event of staff absence. If the roster is unable to be filled by current staff, bureau staff are utilised. All replacements are recorded on the roster.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All required demographic, personal, clinical and other health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes InterRAI assessment information. Records were legible with the date, name and designation of the person making the entry identifiable. Electronic records are password protected.</p> <p>A resident register is maintained that records entry and exit dates. Electronic files are backed up daily on the main NMDT server.</p> <p>Older paper records are held on site until they are able to be disposed of as per policy, and deceased resident records go off site to be archived at the Taradale site (secure archive building). The records in storage are readily retrievable. Electronic files are retained in an archive file. Residents' files are held for 10 years before being destroyed by a secure document removal provider. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the nurse manager. They are also provided with information about the service and the admission process. The organisation seeks updated information from NASC, the general practitioner (GP) and family/whanau for residents accessing respite care.</p> <p>Family/whanau stated they were satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition,</p>	FA	<p>Transition, exit, discharge or transfer is managed in a planned and co-ordinated manner and an escort is provided if family are unable to accompany the resident. The service uses the DHB (yellow bag system).</p>

<p>Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>Risks are identified, and verbal handovers are provided. There is open communication between services, the resident and the family/whanau. At the time of transfer appropriate information is supplied by the person responsible for the ongoing management of the resident. All referrals are documented in the progress records. When transferred back from the DHB the same yellow bag is completed for the receiving service with all relevant information.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medicines management policy is comprehensive and identifies all aspects of medicine management. The services uses an electronic system which is working effectively and safely for the service. The staff interviewed are fully trained in this programme. The GP commented that the system is working well with less errors reported. The staff member observed demonstrated good knowledge and understanding of the role and responsibilities related to each stage of medication management. All staff who administer medicines both registered nurses and senior health care assistants are competent to perform the function they manage.</p> <p>There is a locked office in the dementia house and a large medication room in the hospital care setting. Only registered nurses on shift have access to the locked medication room in the hospital wing. The two locked drug trolleys are stored in these secure areas when not in use. The controlled drugs are checked weekly by two registered nurses and a stamp is used and signed off by the two staff members to verify this has been completed. The contracted pharmacist completes six monthly audits and the pharmacist writes when last reviewed in red ink.</p> <p>The records of temperature monitoring for the medicine fridge were sighted and readings were within the recommended range.</p> <p>The three-monthly medication reviews by the GP are verified on the electronic record maintained.</p> <p>There is one hospital resident who self-administers their medicines as necessary. Documentation is in place to verify this is managed in a safe manner.</p> <p>Medication errors are reported to the nurse manager or RN and recorded on an incident form. The resident and/or family are advised. There is a process for comprehensive analysis of any medication errors and compliance with this process is verified.</p> <p>Medication standing orders are signed off by the GPs. Any pro re nata (PRN) medication administered is documented electronically and the effectiveness of the medicine administered is entered into the system. PRN medication requests include indication for use.</p>
<p>Standard 1.3.13: Nutrition,</p>	<p>FA</p>	<p>Menu plans are developed and implemented with summer and winter seasonal foods. The last menu review</p>

<p>Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>occurred 10 October 2017 by the contracted registered dietitian. The service has a registered food control plan which was verified by the Napier City Council which expires 28 February 2019.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook interviewed and accommodated in the daily menu plan. Any diets or special needs are documented on the whiteboard sighted in the kitchen for staff to follow. Additional food is always available for the residents in dementia house 24 hours seven days a week.</p> <p>The kitchen has clean and dirty areas, has a good work flow and is clean and tidy. Special equipment available to meet the nutritional needs of the residents was sighted.</p> <p>The cook is responsible for all aspects of food procurement, production, preparation, storage, deliveries and disposal and complies with all current legislation and guidelines.</p> <p>A kitchen cleaning schedule is developed and implemented.</p> <p>Evidence of resident satisfaction with meals is verified by residents and family interviews and the sighted satisfaction surveys. The dining room in the dementia service is located near the kitchen and has a homely atmosphere. The hospital residents have their meals in the lounge/dining area in the hospital wing. Staff were sighted assisting residents as needed with their meals.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The nurse manager interviewed verified a process exists for informing residents, their family/whanau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely manner and format that was understood. Where requested, assistance would be provided to a resident and their family with other options for alternative care arrangements or residential services. The facility resident register would be updated and the reason for decline documented.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission to Elmwood House and Hospital residents have their needs identified through a variety of information such as the NASC service, other service providers involved with the resident, the family/representative and on-site assessments using a range of recognised assessment tools. The information is documented and informs the initial care planning process. In the dementia service a 24-hour behavioural chart is developed and implemented for each individual resident to guide staff on how to effectively manage each resident.</p>

		Over the next three weeks the registered nurse (one registered nurse currently completes the interRAI assessments) undertakes an interRAI assessment and other assessments as clinically indicated. Re-assessments post admission occur within 21 days and with interRAI six monthly or earlier if a resident is discharged to another facility or transferred to the DHB. All interRAI assessments are up-to-date at the time of this audit.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Assessment outcomes inform the care plan and describe the required support the resident required to meet their goals and desired outcomes. The care plans reviewed evidence service integration with progress records, activities records, medical and nursing notations clearly written, informative and relevant. Any changes in care are documented and information is shared at time of the handover between shifts. Handover was observed. The care plans are evaluated six monthly and earlier if changes occur. Interviews and documentation verified resident/family involvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observation and interviews verified care provided is consistent with meeting residents' identified needs and desired outcomes/goals. The documentation reviewed addresses all areas of resident needs. Interventions are updated in line with residents' changing needs. Behaviour management is monitored for effectiveness and new strategies are sought if goals are not attained. The GP interviewed verified the care provided is of a high standard. Residents and family members also expressed a high level of satisfaction with the care provided both in the hospital and the secure dementia service. There are adequate resources and equipment observed to meet the needs of the residents.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme at Elmwood House and Hospital is provided by an activities coordinator with the support of the staff. Planned activities are provided five days a week. Residents are assessed on admission to ascertain their needs and appropriate activities and social requirements. The resident leisure/lifestyle profiles are analysed to develop an activity programme that is meaningful to the residents. The planned monthly programme sighted matches the skills, likes, dislikes and interests evidenced in the assessment information. Activities reflect residents' goals, ordinary patterns of life and a van is available for community activities. Group activities are encouraged in the dementia service with most residents participating. Consideration of activities for two under 65-year olds in the dementia service

		<p>are well planned. Entertainment is planned, and newsletters are completed monthly for families and residents with up and coming events. A variety of activities involving exercising, craft, singing and numerous themed social functions are provided. Family are involved when the lifestyle care plan is evaluated six monthly or earlier if required. The activities for the dementia service are planned with activities being available for the 24-hour period. Resources are available for staff to access if needed.</p> <p>The activities provided in the hospital are more individual, but residents can join in group activities if able. Attendance and participation records reviewed are well documented. Evaluations occur after all social functions for quality improvement purposes. Satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered is appreciated.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated each shift and reported in the progress records. If any changes occur the care staff report to the RN.</p> <p>Residents' lifestyle care plan evaluations occur six monthly or earlier if needs change. Where progress is different than expected the service is seen to respond by initiating changes to the plan. Evaluations were sighted in the sample of resident records reviewed.</p> <p>A short-term care plan is initiated for short term issues such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk verified during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek a referral to other health and/or disability service providers if they wish or if clinically indicated. The GP or nurse manager send a referral to seek specialist service provider assistance from the DHB as needed. Referrals are also sent through to the NASC service if a reassessment is required for a resident. Referrals to colonoscopy, eye specialists, radiology and orthopaedic services were sighted in the records. Referrals are followed up in a timely manner. The resident and the family/whanau are kept informed of the referral process as verified in the resident records and interviews. Acute referrals are attended to immediately by sending the resident to an accident and emergency centre or to the DHB by ambulance if the circumstances dictate this should occur.</p>
<p>Standard 1.4.1: Management</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances.</p>

<p>Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Appropriate signage is displayed where necessary. Secure storage is provided for waste awaiting collection for disposal. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Safety data sheets are available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Protective clothing and equipment are provided, and staff were observed using this appropriately.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness is displayed in the foyer of the facility.</p> <p>Facility management staff provide oversight and ensures that the residents' physical environment and facilities are fit for their purpose and well maintained. There is a documented maintenance system in place. Staff knew the processes they should follow if any repairs or maintenance is required. Review of records indicated that maintenance issues are remedied promptly. Interviews with maintenance personnel, review of records and observation of the environment indicate that testing and tagging of electrical equipment and calibration of bio medical equipment is current. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The secure dementia unit is separated from the hospital area by an alarmed door. Key code door locks prevent entry to service areas and office rooms.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The layout and external areas of the dementia unit are level and designed for the safe mobility of residents with cognitive impairment. Paths are paved. The outdoor area is separated from the carpark and storage areas area by a fence with vertical slats and safety catches. Residents and families confirmed they are satisfied with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a mix of ensuite and communal facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Doors are not locked as all residents are attended to during personal hygiene activities. The facilities are appropriately identified using a mix of picture signage and written signage.</p> <p>Hot water temperatures in resident bathrooms are monitored monthly. Records indicate that these are occasionally above 45C. The tempering valves of the outlaying taps were readjusted to 45C and retested on audit day. Hot water tanks are maintained at the required temperature.</p>

assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely. All bedrooms are currently single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported that bedrooms are spacious and meet their needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available in both the hospital and the dementia wings for residents to engage in activities. Each wing has a dining and lounge area separated from each other. There is room for easy access for residents and staff. Residents can access small quiet areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. The secure dementia unit is separated from the rest home/hospital areas. Residents and families reported satisfaction with the communal areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site by a designated laundry person. A well-equipped laundry room is provided. Outside drying facilities are available. The laundry person demonstrated a sound knowledge of the laundry processes, storage, the dirty/clean flow and handling of soiled and infectious linen processes. Sanitization is by both temperature and chemicals according to items being laundered. Equipment is new within the last year and functional and calibration checks have been undertaken. Residents and families reported that their clothes are maintained in good condition and returned in a timely manner.</p> <p>The facility was clean and fresh on audit day. There are designated cleaners who fulfil the cleaning duties. The cleaners have received appropriate training, as confirmed in interview of cleaning staff and in training records. Chemicals are stored in a lockable cupboard and in appropriately labelled containers. Cleaning materials are kept in a basket in the possession of the cleaner at all times that cleaning is being done in the facility. The cleaner understood infection control processes and care of cleaning equipment.</p> <p>There is a cleaning schedule and records indicate it is maintained. Cleaning of carpets and shower curtains is part of the regular cleaning schedule. Cleaning and laundry processes are monitored through a two monthly report from the external chemical supplier and the internal audit programme.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. Staff have completed first aid training.</p> <p>There is an approved evacuation scheme. A trial evacuation takes place twice a year. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies are available for use in the event of a civil defence emergency, including food, water, blankets, torches and mobile phones. Food and water storage are more than adequate for three day's supply. Supplies available meet civil defence guidelines. There is a gas cooker in the kitchen. There is emergency lighting, which is inspected monthly by an external provider as part of the fire/building warrant of fitness checks.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. The garden that can be accessed from the dementia wing is securely fenced off from the carpark and road. Doors and windows are locked at a predetermined time. There is a bell at the front entrance and any visitors can be seen and checked through the window.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms, communal areas and bathrooms are heated and ventilated at a comfortable level. Rooms have natural light and opening external windows. Residents and families confirmed the buildings are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	<p>FA</p>	<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 programme.</p> <p>The infection control programme is reviewed annually by the organisation and establishes and maintains all policies and procedures covering infection control practices.</p> <p>The infection prevention and control practices are guided by an external infection control specialist</p>

<p>and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>organisation's reference materials and assistance from the DHB infection control specialists if needed.</p> <p>The staff interviewed adhere to the policies and procedures in the infection control manual when performing their daily tasks. In addition to this the staff understood when not to come to work and when to return to work after being off sick. Evidence of practice relating to these policies was observed at audit. Reporting lines are defined. Some variances in practice such as having antibacterial gel throughout the hospital is not evident in dementia house due to the nature of the service. Hand hygiene is promoted at every opportunity in both care settings.</p> <p>There have been no outbreaks of infection since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator (ICC) is a registered nurse who has been in this role for three months. Orientation was provided. The ICC is responsible for implementing the infection control programme with the support of the infection control committee currently the nurse manager. More representatives are to be co-opted onto the committee in the coming few months, however the current system is working effectively.</p> <p>The ICC and observation verified there are enough human, physical and information resources to implement the infection control programme. Training records reviewed and interview with staff verified that the ICC attends quarterly infection control training at the DHB and receives regular updates on infection control.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The suite of policies and procedures and guidelines used for infection prevention and control are current and have been signed off by the quality and operations manager. An infection prevention and control flow chart is also available to guide staff on any infection control matters that arise ensuring practicability and safety.</p> <p>Staff interviewed demonstrated they are knowledgeable of infection control policies and understood the principles of infection control. Any resident with potential or known infections are placed in isolation promptly. Methicillin drug resistant organism screening is performed on all new residents for identifying methicillin resistant staphylococcus aureus (MRSA) or extended spectrum beta-lactamases (ESBL). If a clinical risk is identified the necessary precautions are practiced and this is documented on the medical record and as an alert for staff on the individual resident's personal record. A designated form (MRSA ESBL screening & assessment form) is completed. The service has two outbreak boxes fully set up for implementation if and when required. A short-term need- infection form is completed for any infection or for wound care purposes.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verifies staff have received infection control training. Training commences at orientation/induction to the service and is ongoing. Education is provided by an educator across the organisation and from the registered nurses and infection control coordinator. The content of training is documented and evaluated to ensure the content is relevant and understood. The ICC maintains records of attendance. Internal audits are undertaken to assess compliance with expectation.</p> <p>Resident education is provided in a manner that recognises and meets the residents' and families' communication style as verified by resident and family interviews. Hand hygiene is taught to residents and families whenever possible. A record of any education provided to a resident would be documented on the progress records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy for infection control surveillance and monthly surveillance occurs as explained by the ICC. Information is collated monthly and analysed to identify if there are any trends or possible causative factors. Incidents of infection are presented at the quality and staff meetings as verified in the meeting minutes. Any necessary corrective actions are discussed as evidenced in the infection control records, staff interviews and meeting records. Any residents with multi-resistant organisms (MRO) are also discussed as are those on antibiotics. Any immediate action required is presented to staff at the time of handover. Incidents of infections are graphed and displayed in the nurse office and staff room in dementia house. A comparison of previous rates is used to analyse the effectiveness of the programme and evidences a reduction in infections and antibiotic use. The service is well supported by the GP and the contracted pharmacist who sends a list of all residents prescribed antibiotics. This report is sent on the first day of each month. Surveillance is appropriate for the size and nature of the services provided.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation and safe practice policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134:2008). The service's policy was understood by clinical staff interviewed and annual education is provided. The service has no enablers in use at the time of audit but has nine restraints in use. The restraint coordinator is a registered nurse recently appointed to this role has a good understanding of the procedures, practice and the role and responsibilities.</p> <p>Restraint is used as a last resort when all alternatives have been explored. The approval group minutes and records reviewed of those residents who have approved restraints and from interview with staff evidenced this occurred.</p>
<p>Standard 2.2.1: Restraint</p>	<p>FA</p>	<p>The approval group is made up of the nurse manager, restraint coordinator, another registered nurse, the</p>

<p>approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>resident GP and a senior health care assistant. The approval group are responsible for the approval of the use of restraints and the restraint processes as defined in the organisation's policy. There are clear lines of accountability and all restraints have been approved, monitored and analysed.</p> <p>Evidence of family involvement in the decision making as is required by the restraint minimisation and safe practice policies and procedures was clearly documented. The lifestyle care plans are also documented in relation to the restraint 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>	<p>FA</p>	<p>A suite of documents are set up in readiness should a resident require to be restrained. Assessments for the use of restraint were documented and included and met all requirements of the standard. The registered nurses are responsible for completing the initial assessment with the involvement of the restraint coordinator and input from the resident's family/EPOA. The RN restraint coordinator described the documented process. Families interviewed verified their involvement. The GP interviewed is also involved in the final decision on the safety of the use of the restraint. The underlying aetiology, history of restraint use, cultural considerations, alternatives and associated risks. The main objective is to ensure the residents' safety and security. Completed assessments were sighted in the records reviewed of residents who were using a form of restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported with suitable alternatives. When restraints are in use the health care assistants ensure monitoring occurs to ensure the resident is safe. Monitoring forms contain all relevant details. Access to advocacy is provided if requested and privacy is maintained. This is included in the lifestyle care plan and monitoring forms recorded that this had occurred as required.</p> <p>A data base is developed and implemented for recording how many residents are using a restraint and/or an enabler. Information was reviewed and contained all residents currently using a restraint and information to provide an auditable record. A flowchart is available to guide staff on safe restraint use.</p> <p>Staff receive training at time of orientation/induction to the service and education is ongoing. Staff interviewed understood that the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Resident's records reviewed evidenced that individual use of restraints is reviewed and evaluated during the lifestyle care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings held weekly on a Friday. Families interviewed confirmed they are involved at every opportunity in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the standard, including future options to eliminate use, the impact and goals achieved and if the policy and procedure or flow chart was followed and documented as required in the resident records.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator explained the system in place and committee involvement required to demonstrate the monitoring and quality reviews of the use of restraint. The policies and procedures were reviewed 16 November 2017. The committee undertakes weekly reviews of all residents using a form of restraint. Three monthly evaluations in conjunction with the three-monthly multidisciplinary reviews occurs. Six monthly consent renewals occur at the same time the six-monthly lifestyle care plans are evaluated. The GP reviews each resident when completing the multidisciplinary reviews. The restraint report is presented at the quality and staff meetings. Minutes of meetings reviewed confirm this includes the analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use and the competency of staff and the value of the restraint, the education provided and feedback from the GP, staff and families.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>Review of staff files and training records indicated that records of orientation and training are inconsistently maintained. Records of attendance at mandatory training days and fire safety training are kept. Staff interviewed reported they were orientated to the dementia wing prior to commencing work there but records do not specifically document this. Records of orientation of bureau staff prior to commencement of the shift are not maintained. There is no documented process for orientating staff who move into a new role within the facility.</p>	<p>Records of staff orientation and training are inconsistent. Training records do not specifically document orientation to the dementia wing. Records of orientation of bureau staff prior to commencement of the shift are not maintained. There is no documented process for orientating staff who move into a new role within the facility.</p>	<p>Provide evidence of the Identified and documented orientation requirements for bureau staff, the dementia wing, and for staff moving into a new role.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>Medication audits at the beginning of 2017 identified an increasing number of medication errors in the dementia wing. A quality improvement project to reduce the number of reported medication incidents was commenced in Feb/Mar 2017. It was identified that medication blister packs were hard to read with multiple meds in the pack; the pharmacy did not meet the needs of aged care charting/dispensing timeframes as opposed to community needs; the paper medication charts were illegible at times; doctors did not always chart the medications in accordance with medications guidelines; data to monitor the system was difficult to track with the paper-based systems; incident reporting was limited and did not identify what was being missed and therefore what should be tracked via incident reporting. The project investigated the robustness and safety of the paper-based medication system in place at the time, the collection of accurate data to monitor the system effectively, and the quality and responsiveness of the pharmacy system being used.</p> <p>To address the issue, Wi-Fi was installed, and the electronic medication system introduced leading to better detection of medication incidents, improved reporting by staff and improved data and audit trails. As staff became familiar with the new system incident reporting and data increased, resulting in an initial increase in reported incidents per month since January 2017 to an average of 14 incidents per month in January – March 2018. The pharmacy provider was changed, and a robotic medication dispensing system</p>	<p>As a result of the quality project, the accuracy of the medication system in the dementia wing has improved by 66% and been sustained for five months.</p>

		introduced. The medication sachets were distributed in the dementia wing by specifically trained health care assistants. Following a review of staffing levels and competencies, further improvement was achieved by employing a registered nurse to administer medications in the dementia wing from April onwards. An immediate improvement was recorded in April and sustained over the last five months. Medication incidents are now less than 5 per month.	
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End of the report.