

# Harbour View Rest Home (2005) Limited - Harbour View Rest Home

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## Introduction

This report records the results of a Surveillance 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 Health and Disability Auditing New Zealand 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:** Harbour View Rest Home (2005) Limited

**Premises audited:** Harbour View Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 3 April 2019 End date: 4 April 2019

**Proposed changes to current services (if any):** There is a reconfiguration of room G to be a dual-purpose bed for both rest home and dementia use.

**Total beds occupied across all premises included in the audit on the first day of the audit: 44**



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Harbour View rest home is privately owned and operated. The owner is the designated manager. An administrator, registered nurses and care staff support the manager. The service is certified to provide rest home and dementia care for up to 45 residents with 44 residents on the days of audit.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with management, staff, residents, relative and the general practitioner. The residents and relative commented positively on the services and care provided at Harbour View Rest Home.

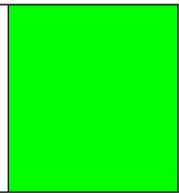
A current room that was being used as a room within the dementia unit has been verified as suitable to be utilised as a rest home room by the opening of another and securing the one to the dementia room. It is intended that this room due to its location can be used as a dual-purpose room depending on the need for a dementia or a rest home bed.

Harbour View has a quality and risk management system in place. Residents and families interviewed were complimentary of the care and support provided.

The previous finding around complaint documentation has been addressed.

This audit has identified a further area for improvement around medication documentation.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The complaints procedure is provided to residents and relatives as part of the admission process. Information is also posted on noticeboards around the facility. There is a complaint register that is up-to-date and includes relevant information regarding the complaint. Documentation including follow-up letters and resolution demonstrates that complaints are well managed. Relatives interviewed confirmed they were well informed of incidents/accidents and changes of health status.

## 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.
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The service continues to implement a quality and risk management programme. Quality activities are conducted, and this generates improvements in practice and service delivery. Residents meetings are held regularly, and residents and families have been surveyed. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and managed. Staff files are maintained, and annual appraisals have been conducted. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Residents and family members interviewed confirmed they were involved in the care plan process and review. Care plans are updated when there are changes in health status. The general practitioner completes an admission assessment, and visits and reviews the residents at least three-monthly.

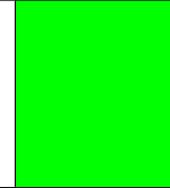
A diversional therapist facilitates the activities programme. The programme is resident-focused and provides group and individual activities planned around everyday activities. Each resident has an individualised plan. Community activities are encouraged, and van outings are arranged on a regular basis.

There are medicine management policies and procedures in place that reflect current guidelines. Medication is managed using an electronic medication management system. The medication charts are reviewed by the GP three-monthly. All staff responsible for administration of medicines had completed education and medication competencies.

A dietitian has reviewed the menu. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food provided.

## 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.

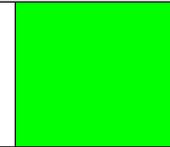


Standards applicable to this service fully attained.

The building has a current warrant of fitness. Internal and external areas are safe and easily accessible for residents and family members. The dementia unit is secure and has a pleasant, secure garden. Rest home residents can move freely around the facility. There is a preventative maintenance schedule in place.

## 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.

Harbour View has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint or enablers.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	15	0	1	0	0	0
<b>Criteria</b>	0	40	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedure are in place. Residents and relatives can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. The complaints register includes all complaints both written and verbal, and includes documentation of correspondence for each complaint. Complaints are logged onto the electronic system, and discussed at meetings. There have been six complaints from January 2018 to date. Appropriate actions have been taken in the management and processing of complaints. Staff are aware of the complaints process and to whom they should direct complaints. The complaints procedure is provided to residents and relatives within the information pack at entry. The previous finding has been addressed.</p> <p>The Ministry requested follow up against aspects of a complaint that included communication, adverse event reporting and service provider availability. There were no identified issues in respect of this complaint</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Five residents interviewed (rest home), stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A sample of twelve incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. Four relatives (two rest home and two dementia)</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>interviewed, confirmed that they are notified of any changes in their family member's health status, and commented on having good relationships with the staff and management. Interpreter services are available as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Harbour View is privately owned and operated. The owner is the manager and has owned and operated Harbour View for 16 years. The service is certified to provide rest home and dementia specific care for up to 45 residents (27 rest home and 17 dementia). This audit included a reconfiguration of room G to be dual-purpose for both rest home and dementia level care as required. The room was verified as suitable to be used for either rest home level or dementia level depending the need. On the day of the audit, this room was occupied by a resident on a short-term carer support contract at rest home level.</p> <p>On the day of the audit, there were 44 residents (27 rest home including the resident in the dual-purpose bed, and one resident occupying a double room in the rest home, and 17 dementia). All long-term residents are under the ARRC contract.</p> <p>Harbour View has clearly defined goals and objectives for business management, quality and risk management and resident service delivery. The mission statement, and vision and values of the services include promoting resident's independence, respecting cultural values and providing a caring homelike environment. An annual review of the quality and risk management programme is conducted. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p> <p>The manager has been in the role for 16 years, is an experienced health administrator, and has attended in excess of eight hour's professional development in the past 12 months. A clinical nursing coordinator supports the manager, she has been in the role for 18 months and has experience in age care. They are supported by an office manager, registered nurses, and long serving staff.</p>
<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</p>	<p>FA</p>	<p>Harbour View has a quality risk management plan in place that is reviewed annually. The manager manages the quality programme and has developed a quality plan for 2019. The service has in place a range of policies and procedures to support service delivery, these are regularly reviewed and discussed at meetings. Discussions with staff (one diversional therapist, one cook, one maintenance, five healthcare assistants (HCA), and two registered nurses) confirmed they are required to read reviewed/new policies. Staff could describe the quality data which includes infection control, incidents and accidents, internal audit results and quality improvements discussed at meetings. Harbour View continues to be restraint free, and this continues to be discussed at meetings. Meeting minutes and quality data are displayed for staff to read.</p> <p>Health and safety policies and procedures are implemented. The hazard register has been reviewed in</p>

<p>continuous quality improvement principles.</p>		<p>December 2018. Health and safety issues are discussed at both the combined health and safety/infection control/quality meetings and staff meetings. There are procedures to guide staff in managing clinical and non-clinical emergencies visible in the nurses' station, and a registered nurse (RN) is on call at all times.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents. Identification of individualised interventions for each resident to minimise future falls are well documented in the care plans. Corrective actions around falls prevention are implemented. Equipment includes; sensor mats, chair alarms, and a sensor/movement alarm, and the use of surveillance cameras in public areas alert to staff to residents' movements. Monitoring forms are in place for residents who require frequent monitoring to prevent falls. Activities are involved and encourage residents to participate in exercises, and Tai Chi is provided by a volunteer. Outdoor areas have been upgraded and are well utilised by residents and relatives. Falls and prevention strategies are discussed at the combined quality meeting and the staff meeting. Staff interviewed could describe a variety of falls prevention strategies used.</p> <p>The annual resident survey has been conducted for 2018, which shows residents are overall very satisfied. The results have been compared to the 2017 results. The improvements implemented from the 2017 survey included the employment of a designated laundry person, cooks taking over serving breakfast, and the activities plan was reviewed, as per resident request. The 2018 satisfaction survey showed an increase in satisfaction in these areas.</p> <p>The improvements following the 2018 resident and relative survey includes upgrading the outdoor areas, which has been completed. The outdoor area in the dementia unit has been upgraded to include renewing the artificial grass carpeting, opening up the back of the area to include a large flat area suitable for bowls, new pot plants and ornaments decorate the area. Since this has been completed, relatives report the outdoor area is utilised more. The other improvement has included changing the cleaning routine to prevent odours.</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</p>	<p>FA</p>	<p>The service collects incident and accident data monthly. The results are discussed at the quality/infection control/health and safety meetings, now held three monthly since January 2019 (previously monthly), and the monthly clinical meetings and staff meetings. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>Twelve incident forms were reviewed (five dementia and seven rest home). All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for all unwitnessed falls and any known head injury. The next of kin had been notified for all incidents/accidents as requested by the relatives. The healthcare assistants interviewed could discuss the incident reporting process, and procedures and protocols in place for dealing with emergencies when registered nurses are not on site. The clinical nursing coordinator collects incident/accident forms, completes investigations and implements corrective actions as required. Relatives interviewed described the 'instruction for reporting form'</p>

<p>in an open manner.</p>		<p>they completed on admission, and reported they are fully informed of all incidents.</p> <p>The manager and clinical nursing coordinator could describe situations that would require reporting to relevant authorities. There have been no notifications required since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Five staff files were reviewed (one clinical nursing coordinator (CNC), one diversional therapist, one cook, one recently appointed HCA, one senior HCA). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. The manager, clinical nursing coordinator and RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the HCAs and the RNs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are three RNs (not including the CNC), two permanent part time and one casual, the two permanent RNs and the CNC have completed interRAI training.</p> <p>Fifteen HCAs work in the dementia unit – a total of seventeen staff across the facility have completed the required dementia unit standards and two are in the process of completing. Three HCAs have not yet completed dementia training standards. The activities coordinator has completed the required dementia unit standards.</p> <p>Twenty-four HCAs have completed Careerforce training. Currently there are five HCAs with level 2, twelve HCAs with level 3, and seven HCAs with level 4. One newly employed staff have not yet commenced training.</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>Harbour View policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home and dementia residents. The manager and registered nurses share on-call after-hours and weekends. Staff interviewed advised that extra staff members can be called on for increased resident requirements. Interviews with staff, residents and relatives identify that staffing is adequate to meet the needs of residents.</p> <p>Staffing is as follows:</p> <p>The clinical nursing coordinator works three days from 11.00 am-7.30 pm and two days 10.00 am-6.30 pm. One part-time RN works 9.00 am-3.30 pm five days a week across the facility.</p>

		<p>In the dementia unit (17 residents at the time of audit).</p> <p>There is one RN on duty from 8.00 am to 12.00 pm three days a week (Monday-Wednesday).</p> <p>On morning shift, there are two HCAs (one is a senior HCA medicine competent) that work a long shift from 6.45 am to 3.15 pm, one HCA works a short shift from 7.00 am to 1.30 pm. On afternoon shift, there are two HCAs (one is a senior HCA medicine competent) 3.00 pm to 11.00 pm, and one HCA works a short shift from 3.00 pm to 9.00 pm. There is one senior HCA overnight. All senior HCAs are medicine competent and first aid trained.</p> <p>Advised that short shifts can be added according to resident needs.</p> <p>In the rest home (27 residents).</p> <p>On morning shift there are two HCAs (one senior HCA) work long shift 7.00 am to 3.00 pm, 8.00 am to 3.00 pm and one HCA works a short shift from 7.00 am to 1.00 pm. On afternoon shift there are two HCAs, (one senior HCA) works long shift 3.00 pm to 11.00 pm, and one HCA works from 4.00 pm to 9.00 pm. There is one senior HCA overnight.</p> <p>The activities coordinator (a diversional therapist) works from Monday to Friday 9.00 am-4.00 pm and an activities assistant works from 10.00 am-2.30 pm on a Friday.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The facility has implemented an electronic medication management system. The registered nurses reconcile the blister packed medication against the individual resident electronic medication charts on delivery. Ten medication chart signing sheets were reviewed (five rest home and five dementia) and reflected medications were administered as prescribed. Medications have been reviewed three-monthly with medical reviews by the attending GP. All 'as required' (PRN) medications have been administered as prescribed including reason for administration and efficacy is documented. However, not all medicines were prescribed on the electronic system.</p> <p>Resident photos and documented allergies or 'nil known' were documented on all ten medication charts reviewed. An annual medication administration competency has been completed for all staff administering medications and medication training had been conducted. There is a self-medicating resident's policy and procedures in place. There were currently two residents who self-administered inhalers, and competencies are in place and reviewed by the RN and GP three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	<p>FA</p>	<p>All food is prepared and cooked on-site at Harbour View. A food control plan is in place expiring 18 January 2020. There are two cooks that cover the seven-day week. They have completed food safety training online. There is a four-weekly rotating menu (summers and winter menus) that has been reviewed by a dietitian. The cook receives notification of any resident dietary changes and requirements. The dementia unit residents have their own dining room and meals are served via a lockable servery hatch. Dislikes and food allergies are known</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>and accommodated.</p> <p>The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request. There is food available 24-hours per day in the dementia care unit. Fridge temperatures are recorded weekly and freezer temperatures are recorded monthly. Food temperatures had been taken and recorded daily. A cleaning schedule is maintained. Expiry dates are documented on storage containers when food was evidenced to have been decanted from the original container. All residents are weighed at least monthly. Residents with weight loss are provided with food supplements. The cook meets with the speech and language therapist to discuss options for residents with swallowing difficulties.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. The cook is part of the combined quality, health and safety and infections control meetings.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>If external nursing or allied health advice is required, the RNs will initiate a referral. Caregivers follow the care plans and report progress against the care plan each shift. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files sampled included a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in place for vital signs including weight, wounds, behaviour management, food and fluid balance charts and pain management.</p> <p>There were four superficial skin tears and a laceration on the day of the audit. All wounds have an assessment, management plan, progress and evaluation. All wound documentation reviewed was fully completed and wound care was evidenced to be occurring within the prescribed timeframes. Photos have been taken to show progression or deterioration of wounds.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>There is a diversional therapist employed who works 30 hours per week, Monday – Friday, with a part-time activities assistant working five hours a week. The activities team are supported by volunteers.</p> <p>The activities team also invite some of the dementia residents to join in the rest home activities programme. Activities are provided for each morning and afternoon from Monday to Friday.</p> <p>Harbour View continues to provide a well-attended activity programme for residents. The care staff deliver the activity programme at the weekends and in the dementia unit when the activities staff are not present. The monthly activity programme is displayed on noticeboards. There are a range of activities to meet most needs including (but not limited to) entertainment, housie, bowls, and games, group exercises and church services.</p>

service.		<p>Variations to the programme are notified to the residents.</p> <p>On the day of audit, activities were seen to be taking place and most residents were actively engaged. The activities assistant has one-on-one time with residents who are unable or who choose not to participate in the programme. There are van outings twice weekly arranged for all residents to enjoy.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six-monthly or earlier if there is a change in health status. Evaluations document progress toward goals. There is at least a three-monthly review by the GP. Changes in health status are documented and followed up. Care plan reviews are signed by an RN.</p> <p>Short-term care plans are used for acute needs and changes in condition. These were either resolved or transferred to long-term care plans. Where progress is different from expected, the service responds by initiating changes to the care plan. Short-term care plans were in place for one skin tear and an infection.</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>	FA	<p>The building has a current warrant of fitness. All hoists, medical equipment and weigh scales have been recently calibrated, tagged and tested. There is a preventative maintenance schedule in place. Hot water temperatures are checked monthly and are within safe parameters. If there are concerns, corrective actions are implemented. There is a secure area for residents in the dementia unit to enjoy the outdoors in a safe environment which has recently been upgraded and surveillance cameras have been installed to public areas to allow for better monitoring of residents. All outdoor areas are easily accessible for rest home residents.</p> <p>Part of the audit was to review the reconfiguration of room G to be utilised as a dual-purpose room. The room is ideally situated on the corner of the dementia unit and the main foyer of the rest home. There are two doors, one to the dementia unit, and one to the main foyer on the rest home side. Each door has a lock, and can be concealed by a sliding door when not in use. The room is spacious, and furniture can be arranged in a variety of ways to suit resident needs. The room has a large window with a view of the harbour and gardens.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>A registered nurse is the infection control coordinator. Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality/ health and safety/infection control meeting, clinical and staff meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the owner/manager and nurses. The infection rate is</p>

that have been specified in the infection control programme.		very low and there have been no outbreaks.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. The facility was not utilising restraint on audit day and no residents had an enabler. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation, enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on restraint and enabler use has been provided. Restraint use audits have been conducted and restraint has been discussed as part of staff and management meetings. The clinical nurse coordinator is the designated restraint coordinator.

## 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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	All medication charts reviewed were clear, and medications have been prescribed correctly. However, oxygen was not prescribed for one resident on oxygen. All charts have been reviewed three monthly. Allergies and photographic identification are evident on all files. All medications are stored in accordance with current legislation. There were no expired medications on site, and a log of medications returned to the pharmacy is maintained. There is a low usage of ‘as required’ antipsychotic medications.	One rest home resident on long term oxygen does not have this prescribed on the electronic system.	<p>Ensure oxygen is prescribed on the electronic system.</p> <p>30 days</p>

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

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

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

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

No data to display
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End of the report.