

Bethsaida Trust Board Incorporated - Bethsaida Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bethsaida Trust Board Incorporated
Premises audited:	Bethsaida Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 April 2019 End date: 1 May 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	47

Executive summary of the audit

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

Bethsaida Retirement Village provides rest home and hospital level care for up to 57 residents. The service is operated by Bethsaida Trust Board Incorporated and managed by a facility manager with support from a clinical nurse leader. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract 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, family members, management, staff, and a nurse practitioner.

This audit has resulted in three continuous improvement ratings in quality improvement, staff education and safe environment and no areas identified as requiring improvement.

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.	Green	Standards applicable to this service fully attained.
--	-------	--

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

Open communication between staff, residents and families is promoted, and 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 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.		Standards applicable to this service fully attained.
---	--	--

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility with support from an experienced clinical nurse leader.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to the development and implementation of multiple organisation-wide 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 annual individual performance and competency reviews.

Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

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

Safe and appropriate environment

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

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

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

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

The overall environment is spacious, light, well ventilated and maintained at a comfortable temperature.

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.
---	--	--

The organisation has implemented policies and procedures that support the minimisation of restraint. According to the register, one enabler and three restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. 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	50	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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>Bethsaida Trust Board Incorporated - Bethsaida Retirement Village (Bethsaida) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services in relation to resident and staff education.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints management policy and associated forms meet the requirements of Right 10 of the Code and include reference to a policy on open disclosure. Information on the complaint process is provided to residents and families on admission when they are also asked to raise any 'annoyances' or concerns. Residents and family members interviewed knew how to lodge a complaint, but none were reported. Residents also have the opportunity to express concerns at residents' meetings with an example being that a resident did not like the toast. Suitable actions to address this were taken.</p> <p>The complaints register reviewed showed that the last complaint was dated 22 January 2018, which was a follow-up complaint to the response for one filed in November the previous year. Documented correspondence provided evidence the issues had been fully investigated and responded to appropriately. A letter from the Health and Disability Commission dated August 2017 confirmed that there was no issue to respond to regarding a complaint filed by a family member earlier in that year.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, and in discussion with staff. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by continuing with community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. For example, attendance at community church. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries.</p>

sexual, financial, or other exploitation.		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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The health practitioner confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the implementation of quality initiatives for any issues or identified gaps.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The Bethsaida Retirement Village is managed by a company that is a wholly owned subsidiary of the Bethsaida Trust Board, a charitable trust that was registered in 1973 and became incorporated in 2006. A 2017 – 2022 Business Plan outlines the vision and mission statement of the Bethsaida Retirement Village. Core values are listed and elaborated within the script. Eight strategies describe how associated objectives will be fulfilled and demonstrated integration of the core values, mission and vision. Business objectives and goals around the expansion process and maintaining occupancy are included in the document.</p> <p>A sample of monthly reports, as presented to the board meetings by the facility manager, showed each has a consistent format and includes adequate information to monitor performance. The reports include information on occupancy, finances and purchases, health and safety, the environment and improvements, as well as copies of reports from the manager, maintenance,</p>

		<p>gardening and the kitchen.</p> <p>This service is managed by a facility manager who holds relevant nursing and management qualifications, has had suitable previous experience and has been in the role for six years. The facility manager reports directly to the Chairperson of the Board. Responsibilities and accountabilities are defined in a position description and an individual employment agreement. Arrangements are in place for a performance appraisal to be completed within the next four weeks. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending aged care and retirement village conferences, in-house training sessions and local DHB aged care meetings.</p> <p>The service holds a contract with the District Health Board to provide rest home and hospital aged care services. Forty-seven residents were receiving rest home or hospital level care services at the time of audit. Of these, forty-five were under the Aged Related Residential Care Agreement contract, twenty-nine of which were rest home level care residents and sixteen hospital level care. One other hospital level care resident is funded by the Accident Compensation Corporation and another pays privately.</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 safe services to consumers.</p>	<p>FA</p>	<p>A suitably qualified and experienced clinical nurse leader is responsible for management of the facility when the facility manager is absent. This person carries out all the required duties under delegated authority and has access to support from board members if required. There are seven other registered nurses on site for additional clinical support while the clinical nurse manager is on leave or undertaking relief duties for the facility manager. Staff reported there is always good access to suitable advice and support.</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 continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. There is an overall culture of quality improvement to address any issues of concern, or to progress new ideas, and this has enabled a continuous quality improvement rating to be allocated for criterion 1.2.3.7. Various aspects of the quality and risk system include management of incidents and complaints, internal audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use.</p> <p>Meeting minutes reviewed confirmed monthly review and analysis of quality indicators is consistently occurring. Related information around quality and risk, health and safety, infection control and restraint are also reported and discussed at these meetings, as well as registered nurse meetings, staff meetings, specialist staff group meetings, and when applicable, residents' meetings. Staff reported their involvement in quality and risk management activities through their</p>

		<p>active participation in quality improvement initiatives, completing incident/accident forms, attendance at staff training updates and reading policy documents and meeting minutes as requested. An internal audit schedule is being adhered to and various departments including kitchen, maintenance, laundry and cleaning provide the facility manager with monthly reports according to a template.</p> <p>When indicated within the quality and risk management processes, relevant corrective actions are developed and implemented to address the shortfalls. As mentioned, quality improvements that may or may not be part of a corrective action are also being implemented. A family satisfaction survey was completed earlier this year and informed that there is overall satisfaction with the services provided. Some comments related to food have since been followed up by the facility manager and the clinical nurse leader.</p> <p>Policies and procedures are developed by a quality consultant in consultation with the manager, the clinical nurse leader and facility staff. These had been updated earlier in 2019 and the review for stage one of the audit showed they are based on current best practice and cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Three staff have completed relevant health and safety training and are familiar with the Health and Safety at Work Act (2015). Relevant requirements have been and are being implemented. The facility manager and the registered nurse leader described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents 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 and analysed with assistance from a system provided through a quality consultant. Information obtained from the analysis and the graphs is reported to the combined health and safety and quality improvement meetings. Any corrective actions or quality improvement opportunities are identified and followed through the quality and risk management system.</p> <p>The facility manager described essential notification reporting requirements related to sentinel events, including for unexpected deaths, police investigations, coroners' inquests, infections and pressure injuries. According to the facility manager there have been no notifications of significant events made to the Ministry of Health 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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications, where required. Records of annual practising certificates for health professionals attending residents were viewed and all were current. A sample of staff records reviewed confirmed the organisation's recruitment policies and procedures are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process has been altered to better prepare new staff for their role. Records of staff orientation processes, including of the associated competencies, were complete. The facility manager and/or the clinical nurse leader has an informal interview at around three months to ensure any training needs are identified.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements, considering the topics that require biennial refreshers. Healthcare assistants have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Performance appraisals are all current with the facility manager responsible for those of non-clinical staff and the clinical nurse leader responsible for those of clinical staff.</p> <p>A continuous improvement rating has been allocated for an initiative that has seen competency reviews and performance appraisals being combined and caseloads allocated to both registered nurses and the health care assistants. The processes and associated reviews have resulted in improved resident safety and service delivery, and improved accountability of resident related documentation and interventions.</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>An annual leave and rostering policy is in place. These documented processes are implemented for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility is not using an official acuity tool but demonstrated how staffing levels are adjusted to meet the changing needs of residents.</p> <p>Staff rosters are completed by the clinical nurse leader who ensures there is a registered nurse on duty at all times, and that all shifts are filled according to a safe staffing roster template. Residents and family members interviewed were satisfied that there are sufficient staff on duty. The service operates as two teams with a duty nurse in charge at each of the two nurses' stations. Four</p>

		<p>weeks of completed rosters were reviewed and confirmed all shifts had been filled, including for unplanned staff absences. There was also evidence of additional staff hours allocated to cover increased demands. All registered nurses have a current first aid certificate and/or a level four cardio-pulmonary resuscitation competency. Likewise, all have a medicine competency. Senior caregivers also have first aid certificates and have varying levels of medicine management competencies.</p> <p>The clinical nurse leader has an allocation book in which health care assistants are allocated to clients according to their skills and experience. A document that details projected staffing levels for the progressive move of 43 to 57 beds has been developed by the clinical nurse leader and was presented to the accountant and the Board of Trustees. Recommendations in this report are being implemented.</p> <p>After-hours on-call arrangements are primarily covered by the clinical nurse leader and the facility manager who share these roles. Staff reported that there is always a registered nurse on duty and that there is good access to advice when needed. Care staff reported there were adequate staff available to complete the work allocated to them for each shift. Although people are working longer hours or extra shifts since the new wings have become occupied, the clinical nurse leader and the facility manager described how this is being managed in a safe manner. Evidence of proactive recruitment processes and new staff orientation that is underway was provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during 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</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and their general practitioner (GP) for residents accessing respite care.</p>

identified.		Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents who were self-administering medications at the time of audit. There is an</p>

		implemented process for comprehensive analysis of any medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Nelson Marlborough district council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and continence assessment, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of seven trained interRAI assessors on site. Residents and families confirmed their</p>

manner.		involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The nurse practitioner interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two activities persons, one whom has almost completed her diversional therapy training.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated each month and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and that it suits them.</p>
Standard 1.3.8: Evaluation	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, mobility and continence. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose to use their own health practitioner. If the need for other non-urgent services are indicated or requested, the health practitioner or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including referrals to a dietitian and medical consultants. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow comprehensively documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary and waste disposal receptacles are available. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets and a spill kit were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 1 July 2019) is publicly displayed.</p> <p>Continuous improvement was evident following the planning and implementation of an initiative to improve the systems in place for monitoring aspects of the residents' physical environment and the safety and reliability of their equipment. These systems complement, and have improved those in place, for testing and tagging of electrical equipment, calibration of bio medical</p>

		<p>equipment, checking the safety of hot water temperatures and checks of mobility equipment including electric beds and hoists, as examples. Increased efforts have been made to ensure the environment is consistently hazard free, that residents are safe, and independence is promoted. Positive feedback from the manager, staff, the maintenance person and external providers was reported and documented.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. Ramps are in place, non-slip surfaces have been laid and seating is strategically positioned.</p> <p>Residents confirmed they know who to ask if something is not working properly and stated that any maintenance requests are appropriately actioned. All stated they are happy 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 assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility with all bedrooms having an accessible combined toilet and shower ensuite. Five other toilets are available throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence with personal hygiene.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around their bedrooms safely. There is sufficient room for mobility equipment to be used in the bedrooms. All bedrooms provide single accommodation, although they are of varying sizes with even the smaller ones being spacious. Rooms are personalised with furnishings, photos and other personal items displayed. There is ample purpose-built storage space throughout the facility for equipment such as wheelchairs and hoists.</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 for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. There is sufficient room for additional equipment and large chairs to be used when required. Residents can access sunroom/lounge areas at the end of different wings around the facility for relaxation or privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>	<p>FA</p>	<p>Laundry is undertaken on site in a large dedicated laundry by laundry staff who are knowledgeable in the processes. Dedicated laundry staff described and demonstrated a sound knowledge of the laundry processes, colour-coded laundry bags, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. One of the cleaning staff interviewed was aware of the safety requirements. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers in locked storage rooms. Residents interviewed stated they are satisfied with the cleanliness of their rooms. Results of the last family survey noted that relatives reported the facility is always clean and tidy.</p> <p>Laundry and cleaning schedules were available. Cleaning and laundry processes are monitored through the internal audit programme and results of these were viewed.</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. The current fire evacuation plan was approved by the New Zealand Fire Service 11 December 2018. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 2 April 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, drinking water, blankets, a first aid kit, mobile phones and gas BBQ's were sighted and meet the requirements for a full contingent of residents and staff. Water storage tanks are located around the complex, and there is a generator on site that is checked weekly. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported that since monitoring of response times has increased staff now respond more promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff undertake security checks at night.</p>
<p>Standard 1.4.8: Natural Light,</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Indoor areas</p>

<p>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>are bright and spacious, rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by heat pumps in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities 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, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external experts. The infection control programme and manual are reviewed annually.</p> <p>The clinical nurse leader is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality committee meeting. This committee includes the facility manager IPC coordinator, the health and safety officer, and representatives from food services, care staff and household management. A report is sent to the governing trustees monthly.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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 IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for over four years. She has undertaken relevant training and attended study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory and health practitioners as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018</p>

<p>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>and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in urinary infections during the hot summer weather.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility manager, clinical leader and IPC committee. Data is benchmarked externally within the electronic system used by Bethsaida and other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>Approved restraints/enablers for use at this facility include a lap belt, bedrails and a fall out chair. On the day of audit, three residents were using restraints and one was using an enabler, which were the least restrictive and used voluntarily at the resident's request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of meeting minutes, files reviewed, and from interview with the restraint coordinator and other staff.</p>
<p>Standard 2.2.1: Restraint 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>FA</p>	<p>The clinical nurse leader is the restraint coordinator. Roles and responsibilities are documented throughout the restraint management policy and procedure. Restraint is managed at the organisational level through the wider infection control/health and safety and quality improvement monthly meetings to which a restraint use report is presented. This team is responsible for the approval of the use of restraints and the overall monitoring and analysis of restraint use.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the person's 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>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse/clinical nurse leader undertakes the initial assessment, seeks input from colleagues, the resident's family/whānau/EPOA and involves the person's general practitioner in the final decision to ensure safe use of restraint. The restraint coordinator described the documented process.</p> <p>Assessment processes identify the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks, as listed on the relevant form. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and with family members. Staff confirmed their reluctance to use any form of restraint but spoke positively about preventive methods such as sensor mats.</p> <p>A review of the file of each person using a restraint confirmed staff reports that when restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Safe levels of documentation around the use of the enablers were also sighted. There have been no requests for an advocate but all processes around restraint and enabler use are ensuring dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each quality improvement meeting. The register was reviewed and contained all residents currently using a restraint as well as the person using an enabler. Sufficient information to provide an auditable record was evident.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the quality improvement meetings, where restraint is discussed. A resident interviewed confirmed their involvement in the evaluation process and their satisfaction with the enabler use process.</p> <p>The evaluation of the use of each restraint use covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and ensuring documentation is completed as required.</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 quality improvement team, where restraint is discussed, undertake monthly and six-monthly reviews of all restraint use which includes all the requirements of this Standard. Minutes of these meetings reviewed confirmed this includes 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, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. There have been no changes required to current policies, guidelines, education and restraint processes. All restraint use is</p>

		individualised.
--	--	-----------------

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.

No data to display

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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>The quality and risk management system is being implemented with rigour and quality improvement opportunities are being identified in all aspects of the system. The various aspects range from internal audit outcomes, meetings, data collection and analysis of various aspects of quality and risk related issues, surveys and corrective action follow-up, for example. Collective information emerging from these ongoing monitoring processes confirmed the value of the results/improvements of the multiple quality initiatives being identified and implemented. This is occurring at a level of organisation-wide continuous improvement.</p> <p>Quality improvement initiatives have been implemented as a result of new innovative ideas, or ways of addressing shortfalls to enhance corrective action follow-up processes. Eleven such examples were developed and followed through during 2018 and five thus far in 2019. Each varied in complexity and the examples covered topics from resident documentation, staff concerns, systems around resident care and activities, environmental improvements and reporting processes such as handovers. The majority of initiatives implemented/under implementation had the potential to positively impact on resident care and support. During interview, staff were aware of these initiatives and of their purpose.</p>	<p>There is a strong culture of continuous quality improvement that filters through all levels of the organisation and for all aspects, of the quality and risk management system. Quality improvement planning, evaluation and review processes are implemented for any identified opportunity for improvement and further enhance the corrective action processes, which overall are intended to improve the residents’</p>

			service delivery, lifestyle and life experience.
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>The clinical nurse leader identified the need to improve staff accountability regarding care services to residents and improve the tracking of clinical documentation to ensure it accurately reflected the residents' individualised care needs and promoted their safety. Part of the plan of action included that registered nurses were assigned caseloads. All clinical documentation for each caseload is checked by the clinical nurse leader on a monthly basis against nine specific criteria to ensure the documentation and all issues for residents are being adequately addressed. The process included helping staff to feel supported in their roles. Strategies used included combining annual performance appraisals and all mandatory competency assessments for all staff members that has ensured all are up to date, which was verified in the staff competency list. Healthcare assistant caseloads for individual resident's care are matched with their identified competencies on a daily basis by the clinical nurse leader. The process of daily staff allocation was described, and records sighted showed these are consistent with the roster and the staff skill levels.</p> <p>Review of the processes by the clinical nurse leader included checking the data on the purpose developed schedule sheets, tracking the registered nurses' caseloads over the month with an individual printout provided to each of the nurses, feedback from residents in multi-disciplinary meetings and in the family survey, and staff reports during their annual performance appraisals and at staff meetings.</p> <p>Findings from the review processes that have been, and are ongoing, include evidence and feedback that there has been an improvement in the delivery of care to residents. Staff are reporting they are now more competent and confident in their roles, that clinical documentation is completed within required timeframes, especially evaluations and reviews, health care assistants are accepting responsibility for the individual daily care of their residents, and the rotation of healthcare assistants has enabled a fair workload whilst staff maintain familiarity with all residents. Continuous quality improvement was evident through the various aspects of this initiative with direct improvements in service delivery for residents, as well as indirect improvements with staff being more satisfied and the documentation more complete and more accurate.</p>	<p>An initiative that has resulted in the combining of staff competencies and performance appraisal processes, registered nurses taking on their own resident caseload and healthcare assistants having rotating daily caseloads is ensuring staff are well informed and competent in their role, promoting safer and more appropriate delivery of care for residents, enabling increased monitoring of residents' documentation and increased accountability around the safety and individualised day to day care of residents.</p>
<p>Criterion 1.4.2.1</p>	CI	<p>In summary, shortcomings were identified by the manager and maintenance person regarding the demands on the role and the responsibilities of the maintenance person. An internal review</p>	<p>A comprehensive review of the systems that ensure</p>

<p>All buildings, plant, and equipment comply with legislation.</p>		<p>of the maintenance systems identified that not all aspects were fully functioning and the recording systems in place were insufficient to ensure resident safety at all times. A team approach that involved the facility manager, the administrator, the quality consultant and the maintenance person was taken. Using the collective skills of the team, information was gathered, planners were formatted, retraining was undertaken, appropriate external contractors accessed, electronic systems set up and consultation processes occurred. It was intended that the project aim to meet the requirements of the standard; however, evaluation and review processes that followed showed some unexpected outcomes. In addition to achieving the intention that all equipment and maintenance related monitoring records are now completed and ensure resident safety, the maintenance person has expressed a new confidence in the role, confirmed that new skills have been acquired and residents reported how much easier it is to request and receive such assistance nowadays. There is now an ability to plan forward to ensure relevant technicians are booked and there is increased reliability of equipment checks from external service providers. Staff confirmed that overall there is now increased attention to residents' safety around their environment, their personal equipment (especially for mobility) is more reliable and there has been an increased awareness of health and safety issues for staff and residents.</p> <p>The comprehensive nature of this initiative, the wide-ranging positive feedback about the differences from the manager, staff, residents and the maintenance person and the clearly defined benefits emerging from the evaluation and review processes has meant a continuous improvement has been allocated for this standard.</p>	<p>buildings, plant and equipment comply with legislation has occurred and has resulted in the implementation of more efficient processes, which have subsequently reduced associated risks, raised associated health and safety awareness and improved the safety of the environment and reliability of equipment for residents.</p>
---	--	---	---

End of the report.