

The Kawerau Social Services Trust Board

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:	The Kawerau Social Services Trust Board
Premises audited:	Mountain View Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 June 2019 End date: 21 June 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:	44

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

Mountain View Rest Home is owned and operated by Kawerau Social Services Trust who also own the small retirement village on site. The home provides rest home and hospital level care to a maximum of 50 occupants.

This re-certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, interviews with residents, family members, board members, management, staff and a general practitioner. Three other registered health professionals (a physiotherapist, a community mental health nurse and specialist renal nurse specialist) who arrived to provide services during the audit were also interviewed.

The manager reported there have been no changes to size or scope of the service. A number of improvements have been made to the interior of the buildings and the external environment since the previous surveillance audit in 2017.

There were no areas identified as requiring improvement. Six areas of continuous improvement were acknowledged for refinement and success with quality systems, improved staff retention, reduction in restraint, improving resident mobility and independence, increased continuity of medical care and services and the outcomes from a resident nutritional project.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

Residents 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, the general practitioner, residents and families is promoted and confirmed by to be effective. There is access to interpreter services if needed. Staff provide residents and families with the information they need to make informed consent and choices.

Residents who identify as Maori 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.

The complaints management system is effective. Residents and their families were well informed about how to raise concerns. There is evidence that the small number of complaints received since the previous audit have been resolved in a timely way and to the satisfaction of the complainant. The Office of the Health and Disability Commissioner are investigating a complaint lodged with them in 2018. The manager advised there have been no issues-based audits, police or coroner investigations.

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.

All standards applicable to this service fully attained with some standards exceeded.

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.

The organisations has well established quality and risk management systems which monitor service performance. This occurs through internal audits, analysing quality data gathered from event reporting such as incidents, restraints and infections and through resident and relative feedback. Where these activities identify that improvements are required, managers and staff determine the best course of action to resolve the matter. Any gaps in service delivery are monitored by re-auditing to test that improvement has occurred.

All incidents and accidents are reported verbally and in written form. These are reviewed and investigated for cause by the charge nurse who oversees all the clinical care in the facility. Staff act in an open and frank manner by acknowledging what has occurred and notifying senior staff, families or the GP depending on the nature of the incident as soon as practicable. The nurse manager understands and carries out notification to the Ministry of Health and the DHB on matters that are required by legislation to be notified.

The service recruits and manages staff using good employment practices. There is a dedicated workforce who are supported to carry out their roles through in-service training and industry education in the provision of safe and appropriate care, food, cleaning and laundry services.

The number of registered nurses, care staff and allied staff on duty for each shift meets safe staffing guidelines and the contract requirements for the level of care provided. A total of eight registered nurses (RNs) are employed to oversee clinical care and there is always an RN on duty and another on call.

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 and family.

The multidisciplinary team including a registered nurse, general practitioner and physiotherapist assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Records 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 and disability 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 requirements and needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. The food service has a food control plan.

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.
--	--	--

Waste and hazardous materials are managed safely. The interior and exterior of the facility is well maintained by a full time employed maintenance person who ensures the buildings and chattels are safe. A current building warrant of fitness was on display. Medical and electrical equipment is tested and serviced regularly. Fire suppression systems are in place and checked as functional by an external contractor. Staff are trained in managing emergencies including fire by attending trial fire evacuations.

Residents' bedrooms, bathrooms and communal areas used for dining and recreation are spacious and comfortable. Chattels are of a good quality and the furniture provided is suitable for use by older people.

All areas are cleaned daily to a high standard. Laundry services are effective and hygienic.

The home is maintained at a warm and comfortable temperature. All areas have opening doors and windows for ventilation.

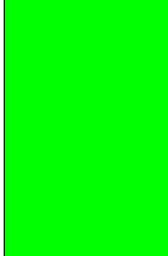
Restraint minimisation and safe practice

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. Three residents were using restraints, and no one was using enablers on the days of audit.

Staff demonstrated in depth knowledge and understanding about the requirements for this standard. Safe practice related to restraint is occurring. Effective procedures for assessment, approval, monitoring and regular review of restraints are implemented.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	---	---

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

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

Aged 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	1	48	0	0	0	0	0
Criteria	5	92	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>Mountain View Home and Hospital 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 the training records reviewed.</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, care staff and the GP interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation's consent form. Advance care planning and advance directives are being introduced and promoted by the registered nurses as well as establishing and documenting enduring power of attorney requirements and processes for residents unable to consent, as sighted in records reviewed. 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>	<p>FA</p>	<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 unaware of the Advocacy Service, how to access this and their right to have a support person of their choice as needed.</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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for maintaining links with their family/whānau and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff and the GP.</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>	<p>FA</p>	<p>The complaints policy and procedures meet the requirements of this standard, the provider's contract with the DHB, and Right 10 of the Code. It also contains references to advocacy and the organisation's quality system, resident's rights, advocacy and resident/family meetings policies.</p> <p>Review of the complaints register and interview with the manager confirmed there have been three complaints received and managed through to resolution since the previous audit. A complaint logged with the Office of the Health and Disability Commissioner in May 2018 is under investigation.</p> <p>Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Code. The residents and relatives interviewed demonstrated an understanding and awareness of complaint processes. Staff attend regular education on the Code of Rights, including the complaints processes. Review of residents' meeting minutes provided evidence of discussion on the Code of Rights and complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service through receiving the information pack on admission and the discussion with the registered nurse during the admission process. The Code is displayed in all service areas of the home. Information is also provided 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. There are no shared rooms at this facility.</p> <p>Residents are encouraged to maintain their independence by joining in activities in the community, visiting family/whanau and participation in clubs of their choosing.</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>The general practitioner (GP) was interviewed and ensured privacy and confidentiality was respected in regard to resident visits and records.</p> <p>Staff understood the service's policy on abuse and neglect including what to do should they suspect or observe any signs. Education on abuse and neglect was confirmed to occur during orientation and annually as sighted in the training plan reviewed.</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 Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice as is the importance of family/whanau. There is a current health plan developed with input from cultural advisers, Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. There are six residents who identify as Maori and twenty-nine (29) staff who identify as Maori. Maori residents and their whanau interviewed reported that staff acknowledge and respect their individual cultural needs. Activities and a special event on the day of the audit evidenced the cultural needs of Maori were being effectively met. In addition, a choice of a 'boil up' was provided for the lunchtime meal and this was appreciated by residents interviewed.</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 the care plans reviewed for both the rest home and hospital level care residents. 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, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family/whanau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation 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. Staff are guided by policies and procedures and demonstrated a clear understanding of the processes they would follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Mountain View Home and Hospital encourages and promotes good practice through evidenced policies and procedures and input from external specialist services and allied health professionals. Opportunities for staff at all levels to pursue education is encouraged by management.</p> <p>The clinical staff highlighted examples of good practice, such as monthly reports for infections, falls, nutrition, restraint minimisation and safe practice, wound and pressure injuries being used to monitor residents' wellness. Infection rates are improving as verified in the infection rate of 21.4% less than the previous year. Incidences of wound and pressure injury remain low. Preventative measures, such as high protein diets, chair gel cushions and repositioning are assisting the prevention programme implemented. Supplementary drinks advised by a nutritionist and advice sought from the tissue viability nurse when needed has been valuable. Upskilling of registered nurses' assessments, providing nurses with additional support to promote prevention and anticipatory intervention has been completed. The registered nurses and care staff ensure that the resident is the centre of their care, promote effective communication, training and up-skilling. Two registered nurses have completed post graduate certificates. Emergency preparedness is outstanding with signage, protocol and processes being well embedded into the organisation to cope with any type of emergency event.</p> <p>The GP interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family/whanau members stated they were kept well informed about any changes to their/their relative's status and 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. The business card for the manager and contact details was provided in the information pack.</p> <p>Staff interviewed knowhow to access interpreter services although reported that this was rarely required due to staff being able to translate as needed, the use of family/whanau and other forms of communication</p>

		as deemed appropriate at the time.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Mountain View Home and Hospital is governed by an eight member Board of Trustees, and day to day operations are overseen by a manager who is a registered nurse (RN) with a current practising certificate. The same person has been managing the facility for nearly 27 years. Personnel records and interview with the manager confirmed their nursing portfolio, clinical skills and knowledge are maintained by attending networking meetings with other aged care providers and regular professional development/education in subject areas related to rest home management and care of older people. The manager is supported by a charge nurse, an operations manager, and an administrator/receptionist, a team leader for food services, and other allied staff for resident activities, housekeeping and building maintenance.</p> <p>The charge nurse has four years work experience in the aged care sector and attends industry specific training to maintain the skills and knowledge required in the aged residential care contract (ARCC). This person oversees the care provided to residents via two RN team leaders. Five other registered nurses are employed to provide 24 hour a day seven days a week clinical care</p> <p>Maximum occupancy is for 50 residents and there are plans to build additional hospital beds as funds allow. Services are configured for 30 hospital level and 18 rest home level beds plus two dual purpose beds. On the days of audit there were 43 residents in the home receiving services under the age residential care contract (ARCC) with the DHB, and one resident was in the public hospital. Twenty five residents were assessed as requiring hospital level care and 19 as requiring rest home care. Mountain View also holds an agreement with the DHB for a day activity programme. All residents were over the age of 65 years and had signed admission agreements. One wing (Putauaki) is allocated for people with various stages of confusion and memory loss and although the area is secure, none of the external doors are locked during the day. It is therefore not a dedicated dementia unit. The opening of this wing has enabled residents to remain in Kawerau rather than being transferred to dedicated secure wings in other towns/cities.</p> <p>Five of the eight RN's employed are certified to complete interRAI assessments and are maintaining their annual competency with this.</p> <p>The annual business plan includes service goals which are being monitored for progress by the manager and the board. The business plan includes a mission statement, values and service scope and identifies the organisation's strengths, weaknesses, opportunities and threats. Interviews with three board members and review of a sample of board meeting minutes confirmed that the board are kept fully informed about residents, occupancy, staffing, adverse events and other aspects of service provision.</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>The service has appropriate systems in place to ensure the day-to-day operations of the service continue should the manager be absent. The RN manager's role is delegated to the clinical nurse manager with input from the operations manager and others as required.</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>A first stage audit and review of policy and procedures confirmed that policy documents are current and cite best safe practice. The documents are reviewed bi-yearly or earlier if required and are controlled in ways that ensure that only the most up to date version is available. Mountain View Home and Hospital had strengthened and improved its approach to quality in a variety of ways that have led to better outcomes for residents. (Refer to 1.2.3.1)</p> <p>Quality and risk activities were integrated and co-ordinated across all aspects of service delivery. A quality team, comprising the manager, operations manager and charge nurse meet every two months to consider quality and risk matters. A sample of quality committee and staff meeting minutes from 2018 and 2019 and the review of quality improvement projects confirmed the service is analysing its quality data (such as accidents/incidents, complaints, infection events, restraint activity, outcomes of internal audits and feedback from residents and family) to determine priorities and improvement. The focus on specific areas for improvement has led to measurable improvements for residents.</p> <p>In other areas of day to day service delivery, corrective action plans were developed where the need for service improvements were identified and are reported at the quality committee meetings. The meeting minutes confirmed that actions were monitored for implementation and effectiveness before being closed off. A monthly narrative and statistical report on quality and risk matters was confirmed by the board members as being effective in keeping them informed. Minutes from a range of staff meetings showed that discussion and reporting on incidents, infections, safety and restraint matters occurs. All staff interviewed clearly understood the service approach to quality and risk.</p> <p>Risk management and occupational health and safety processes were clearly described. The risk management plan was updated annually and identifies all actual and potential business and environmental risks. The sighted hazard register was being maintained and regular environmental inspections were occurring. Residents were being regularly risk assessed using a range of assessment tools including the interRAI assessment tool. The extent of planning and preparedness for emergencies is impressive.</p> <p>Staff are provided regular education on health and safety matters and are supported in the workplace to</p>

		keep themselves free from injury. There had been no staff injuries that required reporting to Worksafe.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The adverse event reporting system was a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. These were reported verbally at handover and in the written summary. Incidents are reviewed by the charge nurses who documents follow up actions. A summary of categorised events is submitted to the manager who reports these to the board monthly. A section 31 notifiable event for a stage 3 pressure injury was submitted to MoH and the DHB on 28 November 2018.</p> <p>There was evidence in the sample of records reviewed and by interviews that the GP and staff understood and implemented open disclosure practices by acknowledging and notifying events to all relevant parties (for example, relatives and the GP).</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>	FA	<p>Human resources policies and guidelines for recruitment and staff management comply with legislation and good employment practices. Professional qualifications are validated before commencement of employment. Copies of the RN's current practising certificates were seen on files. New staff were being recruited according to good employment practices which includes formal interviews, police checking and referee checks. Evidence was sighted in all ten personnel records reviewed.</p> <p>Each new staff member engages in a comprehensive orientation programme specific to their role. The programme includes training and competency assessments in emergency systems. New initiatives have been implemented to encourage the retention of new and existing staff – refer to standard 1.2.8.1</p> <p>Staff learning and development is planned by the operations manager with input from the charge nurse. In-service education sessions on a range of different topics are scheduled over a two year period and individual attendance and achievements are documented. All staff have a running record of training attended and the educational level of each caregiver is recorded. Twelve caregivers have achieved unit standard level 4, 15 have attained level 3, and six have level 2. Two of the new caregivers are enrolled to commence level 2. The activities coordinators have achieved level 4. Staff who are authorised to administer medicines were being competency assessed annually. All staff engage in regular performance appraisals as required by the ARC contract.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	CI	<p>The staff availability policy describes the service approach to staffing. This references The Indicators for Safe Aged Care SNZ 8163:2005. It states that staffing will be evaluated at least annually or when change occurs in residents, core business, goals or size. Reviews and adjustments to staffing have occurred a</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>number of times during this certification period.</p> <p>The sample of rosters for 2019, and interviews with the charge nurse (who develops the rosters) clinical and care staff, residents and families, confirmed there were sufficient numbers of staff on each duty to meet residents' needs. RNs and carers said they are offered extra hours when there are more residents with higher levels of need. On the days of audit, the staff allocation (for 25 hospital residents) was one RN on the floor 24 hours a day and seven days a week (24/7) plus the RN charge nurse who works Monday to Friday and the RN manager. There were four caregivers rostered on each morning, four in the afternoon and two at night.</p> <p>The RN manager who lives on site, is employed to work five days a week between the hours of 8am to 5pm and shares the 24/7 on call with the charge nurse.</p> <p>Staff allocated for care of rest home residents are the RN team leader who works 32 hours per week, three caregivers in the morning, three in the afternoon and one at night</p> <p>Putauaki, an open wing for people with confusion and memory loss is allocated two caregivers with RN oversight and other short shift carers.</p> <p>There are seven cooks who work various hours seven days a week. Three activities co-ordinators are employed for a total of 47.5 hours a week to provide group and individual activities. Frequent and reliable community volunteers also contribute to the activities programme. The volunteers complete an orientation programme and sign confidentiality agreements. Other allied staff, such as the cleaners, laundry staff, administrator and maintenance/grounds staff, are employed for enough hours to complete their tasks.</p> <p>The success of a project designed to retain staff is rated as continuous improvement.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<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 such as Disability Link, Mental Health Services for Older People or Health Services for Older People Bay Plenty District Health Board (BOPDHB). 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 the NASC and/or the GP for residents accessing respite care.</p> <p>Family members and those with enduring power of attorney (EPOA) interviewed stated they were satisfied with the admission process and the information that had been provided to them on admission. Residents' records reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p>

<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>	<p>FA</p>	<p>Processes are in place for managing all stages of service delivery including transition, discharge/death and dying and transfers to another facility or to the DHB. The service uses the 'national yellow bag system' to facilitate transfer of residents to and from acute care services. Included in the envelope/bag is the information details of the individual resident, a copy of the medication record, care plan and the resuscitation status/advance care plan if applicable. There is open communication between all services, the resident and the family/whanau. 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 facility evidenced a smooth transfer process occurred. The family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The 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 hard copy individual medication records for each resident was observed on the day of the audit. The staff 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 by a contracted pharmacist in a pre-packaged format. The registered nurses check medications when delivered against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and at the time deliveries are made to the facility. The pharmacist is also available to provide education to staff on medication management and this was reflected in the training records reviewed.</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 are documented.</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 being met. The required three monthly review is consistently recorded on the medicine record. There were no standing orders in place.</p> <p>There was one resident who was self-administering a medication at the time of the audit. Appropriate</p>

		<p>processes were in place to ensure this was managed safely.</p> <p>There is an implemented process for comprehensive analysis of any medication errors should this be required.</p>
<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 chef 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 (28 February 2019). Recommendations made at that time have been implemented. 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 Kawerau District Council which expires 21 August 2020.</p> <p>Food temperatures including high risk items are monitored appropriately and recorded as part of the plan. The team leader cook has undertaken a safe food handling qualification with all kitchen cooks and assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet the resident's nutritional needs is available. A continuous improvement rating has been made in relation to the nutrition, safe food and fluid management. A registered nurse with a special interest in nutrition works collaboratively with the team leader cook, clinical manager, dietitian and the GP and has set up a comprehensive programme for weight management in the elderly, frail, disabled and palliative care residents as reflected in criterion 1.3.13.1.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes reviewed. 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 no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The clinical manager explained that if the needs of a resident changes and they are no longer suitable for the services offered, a referral assessment to the NASC is made and a new placement found in consultation with the resident and whānau/family. Examples were discussed such as when a resident required higher level dementia care. There is a clause in the service agreement 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 manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, 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 as per the schedule reviewed and maintained by the clinical manager. The interRAI assessments are completed by one of five trained interRAI assessors on site. Family are invited to participate in the multidisciplinary review meetings and families interviewed appreciated being able to have input at this time. Residents and family/whanau confirmed their involvement in the assessment process during all stages of service delivery.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care 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 assessment were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with the progress records, activities records, GP/medical and allied health professionals' notations which are clearly documented, informative and relevant. Any changes in care required is documented and verbally passed onto relevant staff at handovers and to registered nurses and the GP as needed. Residents and family/whanau interviewed 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>	<p>FA</p>	<p>Documentation, observations and interviews verified that care provided to residents was consistent with meeting their needs, goals/objectives 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 GP interviewed verified that medical input is sought in a timely manner and that medical requests are followed by the registered nurses and the care was of a high standard. Care staff confirmed that care was as outlined in the care plan. A range of equipment and resources was readily available suited to the levels of care provided and in accordance with the residents' needs for all residents at Mountain View Home and Hospital.</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</p>	<p>FA</p>	<p>The activities programme is provided by three experienced diversional therapists and two activities coordinators who have worked together for 16 years. The facility is a member of the New Zealand Society of Diversional Therapists. One of the activities coordinators represents the service two monthly at the regional diversional therapist meeting.</p> <p>A social assessment and history is obtained on admission to ascertain residents' needs, interests, abilities and religious/spiritual, social requirements. The activities assessments are reviewed regularly to assist the</p>

<p>to their needs, age, culture, and the setting of the service.</p>		<p>activities coordinators to develop an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review. There are three day stay residents who visit regularly and are encouraged to join in the programme.</p> <p>The activity programme reviewed is provided weekly and all residents have a copy of the weekly programme in their individual rooms. Each day the programme for the day is displayed on a whiteboard in the dining room/lounge. The programme is varied, stimulating, culturally appropriate, interesting and fun as confirmed by residents. Theme days and celebrations of special events are promoted. Interactions and outings into the community are popular including visiting local schools, mystery van trips, church coffee groups, the blokes shed and shopping outings. Two wheelchairs can be accommodated when using the hoist van. Exercises are provided five days a week over and above the activities programme planned by the physiotherapist and assistant physio aide. A kaumatua group visit regularly and a Maori church service is held weekly to meet the cultural needs of the residents. Records are maintained for all activities provided and residents' attendance is also recorded.</p> <p>The activities team interviewed are fully informed of the activities being voluntary for residents to attend. Group and individual activities are planned to meet the needs of all individual residents seven days a week. Residents and family/whanau interviewed confirmed they find the programme stimulating and that the programme meets the interest of the residents. Family/whanau are informed when events are taking place and join in whenever possible.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any changes occurs it is reported by the care staff to the registered nurses/clinical manager.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessments or as a residents' needs changed. 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 wounds, following a fall and for any pressure injuries. When necessary and for unresolved problems, long term care plans are added to and updated. Residents/family/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. The families/whanau interviewed spoke highly of the clinical manager and the GP in keeping them well informed at all times.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP and/or the clinical manager sends a referral to seek specialist input. Copies of referrals were sighted in the residents' records. The mental health community nurse was interviewed when visiting a resident in response to a referral sent from the</p>

<p>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>GP. The GP was visiting at the time so was able to speak directly after the assessment of the resident was completed. In addition, a specialist renal nurse who works with another specialist renal nurse in the community visited Mountain View Home and hospital and was interviewed. Both provided positive feedback about the services provided and confirmed that advice sought was always implemented/actioned by the clinical manager/registered nurses as required in response to the referral being addressed.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to Whakatane Hospital 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>	FA	<p>Policy and procedures contained clear descriptions about disposal methods for all types of human and domestic waste. These includes standards about chemical labelling, the use of protective clothing and equipment and reporting of spills incidents. Sluice rooms were observed to be in a tidy and hygienic condition. Chemical Material Safety Data sheets were available and readily accessible to staff in a number of locations. The hazard register was current. Review of staff training records and interviews with staff who carry out cleaning and laundry duties confirmed that regular training and education on the safe and appropriate handling of chemicals and waste occurs.</p> <p>Visual inspection throughout the facility and observations of staff during both audit days revealed that protective clothing and equipment (for example, gloves, plastic aprons, footwear, and masks) is provided.</p> <p>All chemicals were being stored securely and decanted into clearly labelled containers. The chemical supply company visits each month to check the effectiveness of their products and to support staff with correct handling and use of chemicals.</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 physical environment was safe and fit for purpose. Handrails were installed in corridors, showers and toilets to promote safe mobilisation. All external areas inspected were safe, secure and contained appropriate seating and shade. A floral mural painted on the exterior fence surrounding the Putauaki wing was nominated as a finalist in the New Zealand Aged Care Association (NZACA) awards. All areas of the facility were maintained in very good repair. Medical equipment such as sphygmomanometer, oxygen concentrator, thermoscan and scales were checked and calibrated annually. The current Building Warrant of Fitness expires on 22 November 2019.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	FA	<p>There were sufficient numbers of toilets and bathrooms for the number of residents and additional staff and visitors' toilets. Six bedrooms have attached ensuite bathrooms with shower and toilet, and all bedrooms have hand basins. Inspection of all bathrooms and toilets showed these were in good condition,</p>

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		were disability accessible with easy to clean walls and floor surfaces and were installed with detachable shower heads and electric heaters. Hot water temperatures were monitored monthly. Review of the records for 2017, 2018 and 2019 and hand testing at tap sites reveals temperatures are at or below 45 degrees Celsius.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Each of the bedrooms viewed in the three wings was spacious, with plenty of room to accommodate hoists or other mobility equipment. There was effective curtaining to provide privacy from people passing in the corridors and all rooms were personalised. There were no bedrooms being shared. All the beds provided were electric and in good condition.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each of the three wings has its own lounge area and dining area, and there is one other large communal dining area. One end of the main dining room is used for day time activities and new soundproof doors between these areas had been installed since the previous audit. Residents who do not want to participate in group activities are offered one on one time in their bedrooms or may avoid disturbance by sitting in other areas. The lounge in the hospital wing had been enlarged and completely refurbished. It now includes a galley kitchen with hot and cold water and good bench space. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed said they were very happy with the range of spaces available to them. All furniture is safe and suitable for the consumer group.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Dedicated cleaning and laundry staff are employed seven hours a day, for every day of the week to carry out these services. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. The chemical supplier provides ongoing support and information to staff about safe handling of the products in use and reviews the effectiveness of methods and product use. Current material safety data sheets about each product are located with the chemicals.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	The service is maintaining excellence in emergency preparedness and management. The emergency management plan continues to be reviewed and updated to ensure it complies with best known practice and statutory requirements. Visual inspection of the emergency and disaster room revealed this is fully stocked with good quality and appropriate products and equipment suited for older people. There was

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>sufficient food, water (1,000 litres) and personal supplies stored to provide for the maximum number of residents and carers in the event of a power outage. This meets the requirements as described in the Ministry of Civil Defence and Emergency Management recommendations for the region. The stores are inspected and checked off as still fit for consumption each month. The facility has back up lighting and there is an agreement with the district council for the provision of portable power if needed. Agreement also exists with other care facilities for transfer of residents if the buildings are uninhabitable.</p> <p>The building alterations did not require a change to the current evacuation scheme which is dated 2005. A letter confirming that no change was required was sighted. NZ Fire service attends and observes at least one of the six monthly trial fire evacuations each year. The most recent fire drills occurred on 08 May 2019 and 20 November 2018. Outcomes and learning from these exercises are documented and used to improve protocols. Education posters which describe the different fire alarm tones are displayed in public areas.</p> <p>The grounds are secured by an eternal fence with electric gates and security services patrol each night. There had been no security issues reported.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The home is centrally heated from a boiler system which feeds heat to panel heaters that can be individually controlled in each bedroom and in the communal areas. There were also new heat pumps installed for warmth and cooling in the summer in the hospital and Putauaki wings. Maintenance staff confirmed that the heating systems were running smoothly. The heaters in each bathroom were functional. The home had sufficient doors and external opening windows for ventilation. All bedrooms had good sized external opening windows which are designed and installed to be secure. The residents and relatives interviewed confirmed that internal temperatures and ventilation are comfortable during summer and winter months.</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 an advisory service which supplies all infection prevention and control material for staff to access. The reference material and the infection control programme and manual are reviewed annually. The manual was signed and dated to evidence the programme had been reviewed last on 13 February 2019.</p> <p>A senior registered nurse is the designated IPC coordinator whose role and responsibilities are defined in a job description. The ICC works closely with the clinical manager. Infection control matters, including surveillance results are reported monthly by the RN to the clinical manager who reports to the manager.</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 home. The Infection control manual provides guidance for all staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role and has been in this role since 2016. Annual in-service education is provided to non-clinical and clinical staff as per the training records. Additional support and information is accessed from the infection control nurses at either Tauranga and/or Whakatane Hospitals, the IPC adviser for the contracted IPC provider, the laboratory pathologist, GP and/or the local contracted pharmacist. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of infection. There have been no outbreaks since the previous audit.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	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 February 2019 and included all appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as use of hand-sanitizers, good handwashing techniques and use of personal protective equipment (PPE). Resources were readily available, such as disposable aprons and gloves. Hand washing and sanitiser dispensers are accessible around the facility. Staff interviewed verified knowledge of infection control policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers,	FA	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 was evidence that additional staff education has been provided in response to this.

support staff, and consumers.		<p>However, this has not been an issue for some time with evidence showing a reduction of infections over several years. Comprehensive records are maintained.</p> <p>Resident education is generally on a one-to-one basis and hygiene is discussed at the resident's meeting held regularly.</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>	FA	<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 skin conditions. The annual infection prevention and control report for 2018 was available. The IPC coordinator reviews all reported infections and these are documented. Any 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 any trends for the current year and comparisons against the previous years and this is reported to the clinical manager. The clinical manager reports to the manager who reports results to the board. Results are displayed in the staff room. The infection rates at this facility are below average for this sector. There have been no outbreaks for four years.</p> <p>The GP, the IPC coordinator and the clinical manager work collaboratively in managing antimicrobial usage at Mountain View Home and Hospital and antibiotic prescribing is decreasing with improved management of infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service policies meet the requirements of these standards and provide clear guidance on the safe use of both restraints and enablers. On the days of audit, three residents were using bed rails and/or lap belts as restraint interventions and there were no enablers in use.</p> <p>The restraint coordinator has succeeded with efforts to significantly reduce restraint usage throughout the home. See criterion 2.2.3.2 for evidence of continuous improvement.</p> <p>Policies and procedures for approval, consent, monitoring and review are fully implemented and were known by the care staff interviewed.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p>	FA	<p>The nominated restraint coordinator is the RN team leader for the facility. This person visited other care facilities, studied the standard and international research and then reviewed the service approach to determine other ways to avoid the use of restraint. The processes for assessment and approval ensure</p>

<p>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>that restraint is only used as a last resort.</p> <p>Approval and accountability for use of restraint is documented in policy and the restraint coordinator role description. Approval to use restraints are only granted by the restraint approvals group, which includes the charge nurse and the GP. Potential restraint is not considered until all possible alternatives have been tried and a comprehensive assessment is completed. Review of the documents for each of the three approved restraint interventions, showed that valid consent had been obtained by the resident's authorised next of kin (NoK) or welfare guardian.</p> <p>Staff meeting minutes showed that use of restraint, policy and procedures and related topics are discussed frequently. Staff attend mandatory education and must pass an annual restraint competency test. The staff interviewed understood that the use of restraint is intended to be minimised and how to maintain safety when a restraint is in use.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The three residents' records reviewed, contained evidence that a comprehensive assessment of the resident's status and risks had been conducted prior to implementing the restraint intervention and that alternatives had been tried.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The restraint coordinators review and changes to the service approach for use of restraint, has significantly reduced how frequently restraint is used. The alternatives to restraint sighted in use throughout the home are keeping residents safe from harm and are not impeding their independence or mobility. The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated. For the first half of 2018 there was one resident requiring restraint.</p> <p>Where restraint is the only safe option, a unique restraint management plan for each resident is developed and reviewed regularly. These contains details about the risks related to that individual and step by step instructions on when and how to apply the restraint to maximise safety. The frequency and methods for monitoring the resident whenever the restraint intervention is being used, is described in the restraint management plans. Records of monitoring forms sighted confirmed that use of the restraint is being accurately recorded by staff on all shifts and includes descriptions of cares provided when the restraint is in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed by the restraint coordinator every three months or earlier if indicated and is also evaluated during care plan and interRAI</p>

of restraint.		<p>reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of this Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Interviews and the documentation sighted (for example, the documented 2017 and 2018 annual quality review, RN and staff meeting minutes) confirmed that comprehensive review of restraint use/trends has been occurring since the previous audit. The restraint coordinator consults with the charge nurse, manager and operations manager about the frequency and efficacy of staff education on restraint and whether changes are required.</p>

Specific results for criterion where corrective actions are required

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

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

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

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 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>The extent of the charge nurse evaluation of incidents and accidents demonstrates best quality assurance practice. The documented evaluation includes considering all antecedents to incidents such as falls or skin breakdown, post incident reviews using closed circuit television (CCTV) and staff interviews and referral to the physiotherapist, the falls prevention RN or the nutritional programme RN. These were all monitored for improvements.</p> <p>Three RNs were delegated responsibility for specific areas of resident welfare. The annual reports for 2017-2018 completed by these RNs related to restraint, resident nutrition and falls prevention all showed measurable improvements</p> <p>Additionally, four quality improvement projects have led to better outcomes for residents. These include:</p> <ul style="list-style-type: none"> The refurbishment of a wing for confused residents with various degrees of memory loss. Transfers from Mountain View 	<p>The changes to the extent and detail in quality reporting, analysis and the follow up actions that are monitored and measured for improvement, demonstrated increased focus and robust processes for ensuring quality improvements and improved outcomes for residents.</p>

		<p>Home to dedicated secure care has reduced from on average 10 a year to two transfers over a four year period.</p> <ul style="list-style-type: none"> • A project to improve staff retention. See evidence in 1.2.8 • Improvements to resident strength and mobility. See evidence in 1.3.3. <p>Continuity of medical care through securing the services of one general practitioner for all residents.</p>	
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	CI	<p>Comments from residents in 2017 about the number of new staff, led the provider to consider ways to improve staff retention. The senior management team revised their systems for people recruitment and management, which resulted in adding more support and resources and hours to new staff orientation. The team leaders and RNs attended training in leadership and communicating and working confidently and positively in a culturally diverse workplace. Enhancements were made to the working environment. These included creating a new air-conditioned staff room, introducing new incentives and awards schemes, creating a staff and residents kapa haka group and implementing a staff wellness programmes. The 2018 staff satisfaction survey scored 100% of staff saying they felt supported, feeling proud of the services they provide to residents and that they were happy in their work. The percentage of staff continuing in employment more than doubled from 2016 to 2018.</p> <p>Positive feedback from residents and their families also increased, especially in areas about staff knowledge and understanding about care of the residents.</p>	<p>Continuity of care to residents has been enhanced by improving staff retention. The number of staff retained for more than a year improved from 34% in 2016, to 50% in 2017 and 78% in 2018. Resident and relative feedback about care and how well staff knew the residents scored 100% at the last survey.</p>
<p>Criterion 1.3.13.1</p>	CI	<p>The nutrition annual report was reviewed. Clear objectives, an implementation plan and interventions were clearly</p>	<p>The achievement of an initiative related to weight management is rated beyond the</p>

<p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>documented by the registered nurse. Monthly weighs are undertaken to ensure any variances in weight and wellbeing are addressed in the first instance by identifying specific problems or conditions contributing to a decline in nutritional and hydration status. The current weight recorded was compared by the RN to the previous weight identifying residents who had sustained a significant weight loss of 2kgs or gained in weight 2kgs. The weights are checked with body mass index (BMI) categories based on the MoH guidelines. The RN discusses each case with the team leader cook and different interventions are considered for the individual resident, for example, changes in size of meals, needing more assistance in feeding, problem with swallowing and/or food consistency. Any palliative care residents are included in the report but classified as palliative. Referrals to other health care professionals are made (eg, to the GP, speech language therapist, mental health, dietitian or others as needed). The checking of resident's BMIs was an important indicator for resident's wellness. Early detection of any risk factors such as dysphagia, or dental problems, disease processes like dementia and/or depression or medications that affect appetite were seen as vital. InterRAI data also has assisted the RN to see and compare the percentages related to resident's nutritional status nationally.</p>	<p>expected full attainment. The comprehensive weight management electronic tool introduced records electronically the monthly weights of all residents. The electronic programme alters the previous weight, current weight, loss/gain, body mass index (BMI) and outcome, for example, underweight, overweight, obese or appropriate weight. From the information gained, the multidisciplinary team discuss recommendations and initiatives to be put in place depending on the outcomes desired for individual residents, with family input. (eg, Ice cream has been introduced for a resident rather than the caloric supplement previously provided). The family/resident interviewed is now putting on weight and the resident's general well-being has improved. Family interviewed spoke highly of the improvement observed for their family member.</p>
<p>Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>CI</p>	<p>Mountain View Home and Hospital has access to a multidisciplinary team for the provision of care and supports to residents. Part of this team involves input from a contracted physiotherapist who works over and above the initial contract hours. The physiotherapist assesses all new residents on admission and documents progress on an ongoing basis. Comments from two residents with regards to wanting to improve their physical health prompted the request for approval for a special project to trial for two hours per fortnight of physiotherapy time paid for by Mountain View as access to the DHB physiotherapist was very difficult to get due to the rural location of this service. The plan was to build a relationship with</p>	<p>The achievement of the initiative relating to improvement for residents' mobility and independence is rated beyond the expected full attainment. The residents' progress has been closely monitored by the physiotherapist and evaluated and the findings and improvement to service provision have been recognised and reported to management. The falls risk cards evident and displayed on the outside of the resident's rooms, in the documented records and on the walking aides used by residents are easily identifiable</p>

		<p>a local physiotherapist who would be willing to visit Mountain View on a regular basis and support the project and to use the visits to help residents improve their physical and emotional health with individualised exercise programmes for residents on the trial. In addition, the physiotherapist assesses residents who were potential falls risks so that staff could correctly identify the risk and put interventions in place. This service has been successful in improving outcomes in terms of increasing the level of confidence and ability for residents and staff to deliver appropriate care and to identify the early warning signs of potential residents at risk.</p> <p>Mountain View Home and Hospital provides care for up to 50 residents in a rural area of New Zealand. Medical services are limited and were only available during weekdays from 8am to 5pm. There were no after-hours medical services. Medical cover was provided by a medical centre and one doctor would visit each week within a two-hour time frame allocated to the home. A different doctor visited each time and there were conflicting views amongst the doctors in regard to treatment interventions. If a resident's condition changed residents were often sent directly to the DHB. Hospitalisation records reviewed 27% of admissions could have been prevented. In 2017 a continuous improvement plan was established to improve continuity of medical care to the residents and to decrease the number of unnecessary admissions to the DHB. A plan was instigated to approach the local medical centre and negotiate a contract for one GP to provide the medical services and to work in partnership with the registered nurses to ensure residents' needs are met. A contract was established April 2017.</p>	<p>as to what level of risk for the resident. Staff maintain the exercises set for each of their residents and provide positive reinforcement to build their confidence. Feedback from family/whanau, residents, staff and the physiotherapist were evaluated and the pilot project which was successful was extended to an advanced group. Staff awareness for falls prevention and management has increased, with resident and family feedback being positive. Some residents may not have progressed as far physically, but the project has improved their emotional health and therefore their quality of life.</p> <p>The achievement of the project to contract one GP in April 2017 with cover provided as necessary for the doctor for annual leave or other leave has proved valuable for continuity of service delivery. Action and review has occurred with monthly preventable hospitalisations being tracked and feedback from residents and family/whanau sought. Positive results over the last two years have included continuity of medical care, residents have advance care plans or advance directives in place that guide the care of the residents and this is reviewed annually. Reduced delay in medical intervention and nurses can access the GP who is now familiar with the residents and families. Additional surveys performed which included the GP coverage of this service evidenced that the RNs commented positively on effective communication with the GP. 83% resident satisfaction and 100% family/whanau satisfaction was recorded in April 2019. The GP interviewed was passionate about aged care and displayed a commitment to the role.</p>
--	--	---	---

<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	<p>CI</p>	<p>The restraint coordinator (who is the RN team leader for the service) has succeeded with efforts to significantly reduce restraint usage throughout the home. The restraint register showed a gradual decline from on average 13 restraint interventions in 2016 to three at the time of audit. For the first half of 2018 there was one resident requiring restraint.</p> <p>This has been achieved by procuring more equipment and working with management, the other RN's, the GP, physiotherapists and staff to persist in trialling various alternatives for keeping residents safe from harm. Thorough and ongoing reviews about the need for restraint have led to discontinuation.</p> <p>There was evidence of alternatives to bedrails, such as ultralow beds, fall out mattresses, sensor mats and barrier guard mattresses being used. Each approved restraint has a unique restraint management plan which contains details about risks to the individual resident and step by step instructions on when and how to apply the restraint and the monitoring requirements. These are reviewed regularly.</p>	<p>New approaches and procurement of more equipment has significantly reduced the frequency of restraint usage throughout the home without compromising resident safety.</p>

End of the report.