

Masonic Care Limited - Masonic Court Rest Home and Hospital

Introduction

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

The audit has been conducted by 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:	Masonic Care Limited
Premises audited:	Masonic Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 July 2019 End date: 19 July 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:	46

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

Masonic Court Rest Home and Hospital provides rest home and hospital level care for up to 49 residents. The facility is owned by Masonic Care Limited and is managed by a facility manager who is a registered nurse. Residents and families spoke positively about the care provided.

This certification audit was undertaken to establish compliance with the Health and Disability Service 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, families, management, staff, nurse practitioners and allied health professionals.

Continuous improvement ratings have been awarded relating to end of life outcomes, accessing general practitioners after hours and a reduction in residents falling.

There are no areas requiring improvement from this audit.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Masonic Court Rest Home and Hospital. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations undertaken by external agencies since the last audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan includes a purpose, vision, values and goals. There is regular reporting by the facility manager to the chief executive officer who reports to the board.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by two clinical nurse leaders and a quality/education coordinator.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff, resident, registered nurse (RN), health and safety and quality meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place. Human resource processes are followed. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager is rostered on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic and hard copy files.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Masonic Court Rest Home and Hospital works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

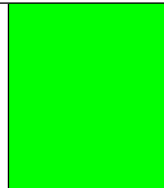
The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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.

A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation with adequate personal space provided. Lounges, a dining area and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

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 service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was a resident using restraint and residents using an enabler at the time of audit.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

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 with data analysed, trended, benchmarked 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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Masonic Court Rest Home and Hospital (Masonic) has policies, procedures and processes in place 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis.

<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. Brochures related to the Advocacy Service were also displayed and available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p> <p>A village resident is an on-site resident advocate who offers residents advice and support if needed. Interview with the advocate verified they are aware of the national advocacy service and the ability to assist residents to access this service if required. The advocate verified residents' satisfaction with the services provided by Masonic, and the prompt responsiveness by management in dealing with any areas of dissatisfaction</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 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' families 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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and 'service improvement' forms available at the main entrance and hospital area. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed evidenced any required follow up and improvements have been made where possible.</p> <p>The facility manager (FM) is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The FM reported there have been no complaint investigations by the Health and Disability Commissioner (HDC), Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous surveillance audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Interviews with residents of Masonic and family members of residents verified they are made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a 'suggestion regarding areas for improvement' 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>	FA	<p>Residents and their family members confirmed that they receive services from Masonic in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the General Practitioner (GP) or Nurse Practitioner (NP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. Brochures on elder abuse are available at reception.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There was one resident and two staff members at Masonic at the time of audit who identified as Māori. A resident who lives on site in the Masonic Court Village identifies as Maori, is a kaumatua, and provides residents and staff with cultural and spiritual support. Interviews verify staff can support residents 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 to Māori residents. There is a current Māori health plan developed with input from the cultural adviser. The Maori health plan is included in the file of the resident who identifies as Maori.</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>	FA	<p>Residents of Masonic verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported 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>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A NP expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Masonic encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, physiotherapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The ongoing in-service education provided to staff is delivered by outside speakers to enable staff to receive up to date education in line with best practice standards. Staff reported they receive management support for access to external education (conferences and off-site seminars) and access their own professional networks, such as on-line forums and training hubs, to support contemporary good practice.</p> <p>The NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Other examples of good practice observed during the audit included a commitment to focus on improving the quality of palliative care provided at Masonic (refer criterion 1.2.3.7), a commitment to improving the access of GP/NP services after hours, and enable continuity of resident care at Masonic (refer criterion</p>

		1.3.3.4) and the implementation of an initiative that has resulted in a reduction in the number of falls (refer criterion 1.3.6.1).
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or 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. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the Mid-Central District Health Board (MCDHB) when required. Staff knew how to access the service.</p> <p>Masonic offers the residents access to free Wi-Fi, and several residents communicate with family and friends via the internet. Residents of Masonic also have access to a 'Smart View' machine, which enlarges the article residents want to read, enabling them to independently read their mail, or the newspaper. A quarterly newsletter keeps residents and family members up to date with the happenings at Masonic.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Masonic Care Limited is governed by a trust board that is responsible for the service at Masonic Court and is responsible for setting the strategic direction. A strategic business plan 2016-2021 includes a purpose, vision, mission and values. There are four goals: to be sustainable; to provide consumer centred care; to achieve on-going quality improvements and to be the best place to work. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>The FM provides a comprehensive report to the chief executive officer (CEO), monthly. The report includes, but is not limited to, reporting on occupancy, staffing and human resources management, quality data, interRAI assessments, and general comments. The FM and CEO reported they meet at least monthly and discuss the activities at Masonic Court via phone at least two weekly. 'Quad meetings' are held quarterly and all managers and quality coordinators within the group meet physically to discuss a range of subjects.</p> <p>The facility manager (FM) who is an RN was appointed to the position in November 2017 and has held management positions including in the aged care sector. The facility manager is supported by two clinical nurse leaders(CNL) and a quality/education coordinator who is a registered nurse. The clinical nurse leaders along with the FM are responsible for oversight of the clinical service in the facility. Interview of the facility manager and CNLs and review of their personal files evidenced they have undertaken education in relevant areas.</p> <p>Masonic Court is certified to provide 49 residents with hospital level and rest home level care. On the day of</p>

		<p>audit there were 46 residents - 15 hospital level and 31 rest home level care. Six bedrooms adjacent to the hospital wing have been approved as dual-purpose rooms.</p> <p>Masonic Court has contracts with the DHB for aged related residential care services, long term chronic health conditions and complimentary care (respite) services.</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>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the FM be absent. The clinical nurse leaders would be responsible for the day-to-day management of the facility during the facility manager's absence. Support would be provided by the quality/education coordinator/RN.</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>	FA	<p>The quality management plan 2019 guides the quality programme and included goals, objectives, risk, document control and quality targets. Quality data is collected, collated and analysed, including audits, incidents/accidents, surveys and clinical indicators and data is entered into an electronic programme provided by an external company. They provide graphs, quarterly reports and benchmarking with other like facilities. Registered nurse, staff, health and safety, quality, infection control and resident meetings are held regularly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff on corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this.</p> <p>Satisfaction surveys for 2018 have been collated and corrective actions put in place. Review of results evidenced a high rate of satisfaction with the service.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures have been reviewed and were current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan included a matrix and risk register that is comprehensive and included risks associated with clinical care, human resources, legislative compliance, contractual and environmental risk. The hazard register included actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is the FM and is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</p>

		A continuous improvement rating has been awarded under 1.2.3.7 relating to providing a more effective end of life experience for residents and their families.
<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>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's Health Status. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The FM reported there have been one section 31 notification to the Ministry of Health since the last 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>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files are managed well and included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>The education programme is the responsibility of the quality/education coordinator. There was good evidence of in-service education provided for staff and documentation evidenced this is provided in several ways including half day sessions every six weeks, some taken by external educators, online learning and RNs attending sessions at the DHB and hospice. Individual certificates of training including competencies are held electronically. Staff are required to complete a questionnaire if they do not attend in-service education. Four of the nine RNs are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files.</p> <p>Staff performance appraisals were current. Annual practising certificates were also current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance</p>

		appraisals.
<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>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. The service uses an electronic programme to ensure safe staffing levels. The rosters evidenced staffing levels exceed the minimum requirements. The FM reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. The FM works full time Monday to Friday. One clinical leader/RN works in the rest home area and the other works in the hospital area on the morning shifts plus another RN working on the floor. Registered nurse cover is provided seven days a week over the 24-hour period. One RN has recently completed the competency assessment programme (CAP) course and has 12 months working as a caregiver in the facility prior to graduating. All other RNs are experienced in aged care and have been employed for at least three years. The FM reported there is a pool of casual RNs and caregivers when shifts are short and agency staff are used if needed. There are dedicated cleaning and laundry staff. A diversional therapist is employed full time.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is 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>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. 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>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	<p>Residents enter Masonic when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM). They are also</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>provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files 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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the MCDHB pink 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. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. 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 was 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. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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 include 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 electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate</p>

		<p>processes are in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the FM and clinical leader (CL) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Masonic.</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 at Masonic is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in April 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Palmerston North City Council. The second round of verification audits have taken place. One finding around documenting cooling temperatures has been addressed with the new plan now approved for 18 months.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook 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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of residents' high level of satisfaction with meals was verified by resident and family interviews, satisfaction surveys, food satisfaction feedback and resident meeting minutes. The cook dishes up dessert in the rest home dining room every day and responds promptly to any areas of residents' dissatisfaction with meals, by adjusting based on feedback. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</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</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 with the FM.</p>

<p>consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>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 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Masonic are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed showed that initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changed. Interviews, documentation and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents, apart from the resident recently admitted, have current interRAI assessments completed by four trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed. An initiative to address the number of falls and the correlation with the number of showers, is an area identified as one of continuous improvement.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was 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 Consumers receive adequate and appropriate services in order to meet their assessed</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of 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 NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the</p>

needs and desired outcomes.		residents' needs.
<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 a trained diversional therapist.</p> <p>A social assessment and history are 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 regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included a residents' gardening group that grows vegetables for use in the kitchen, a residents' knitting group, jigsaw sessions, church services, visits to and by another rest home, playgroup visits, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Friends and family of residents meet every three months socially at Masonic, to mix and mingle with the FM and each other on a social level. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is 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. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau 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</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a</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>referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>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>Documented processes for the management of waste and hazardous substances are in place. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The company representative that supplies chemicals visits monthly and provides training. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p> <p>There is protective clothing and equipment appropriate to recognised risks. There was protective clothing and equipment sighted in the sluice rooms and the laundry and this was being used by staff.</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 was displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. Residents and families stated they can move freely around the facility and that the accommodation meets their needs. The passageway in the hospital area has been refurbished and cupboards removed which has made the area wider.</p> <p>The maintenance person interviewed works four days a week and has good knowledge of requirements. There are robust maintenance systems implemented. A proactive maintenance programme is in place and a reactive maintenance book for staff to enter any maintenance required has corrective actions completed and sign off. Plant and equipment are maintained to an adequate standard. Testing and tagging of equipment and calibration of biomedical equipment was current. Hot water temperatures are within the recommended range.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas including a large wooden deck off the main dining room/lounge. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>

		Residents and families confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned.
<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>One bedroom has a full ensuite and five have a wash hand basin and toilet. There are adequate numbers of communal bathrooms and toilets throughout the facility. Residents reported that there are sufficient toilets and they are easy to access with vacant/engaged signage.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote resident's independence.</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>Bedrooms provide single accommodation with a mix of sizes. Six bedrooms have been approved next to the hospital bedrooms as dual purpose. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents and families spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheelchairs.</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>There are various areas for residents and families to frequent for activities, dining, relaxing and for privacy. The areas are easily accessed by residents and staff. Residents and families confirmed this. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	<p>All laundry is washed on site. Residents and families reported the laundry is managed well and resident's clothes are returned in a timely manner. The laundry person demonstrated good knowledge relating to laundry processes.</p>

<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Cleaners have received appropriate education. Interview of one of the cleaners and training records confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. All equipment used for cleaning is colour coded. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</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>The fire evacuation plan was approved in December 2008. A fire drill takes place six-monthly, the last held in February 2019. There is an evacuation policy on emergency and security situations and covers service groups at the facility. Earthquake and emergency procedures were observed throughout the facility. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures.</p> <p>Staff have current first aid certificates. There is always at least one staff member rostered on duty with a current first aid certificate.</p> <p>Required fire equipment was sighted and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies of water and food in the event of a civil defence emergency that meet the Ministry of Civil Defence and Emergency Management recommendations for the region. Blankets, cell phones and a gas BBQ are also available.</p> <p>Call bells alert staff. Residents and families reported staff respond promptly to call bells.</p> <p>Contractors must wear names badges and sign in and out of the facility. They are also made aware of any hazards on site.</p> <p>The external doors are locked in the evenings and an external firm is contracted for security at night. Sensor lights are situated around the exterior of the facility.</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>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps and panel heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. Residents and families confirmed this. All resident areas are provided with natural light. A covered designated smoking area is provided outside the facility.</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 provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at facility level with input from the FM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the FM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The facility's quality co-ordinator and FM are informed of any IPC concern.</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 related 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 infection control co-ordinator (ICC) has appropriate skills, knowledge and qualifications for the role, and is being assisted by the FM. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external IC advisory company is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and FM 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 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</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified infection control experts, the FM and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and 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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and FM review all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</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 demonstrated that the use of restraint is actively minimised. One resident was using a restraint compared with five at the last audit. Equipment used to reduce the use of restraint includes sensor mats and low low beds. Four residents were using enablers during the audit. Residents' files demonstrated the process for residents using enablers is the same as for the resident using restraint.</p> <p>The FM is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation and safe practice. The FM stated the aim is to have a restraint free environment at Masonic Court. The restraint</p>

		and enabler registers were current. The policies and procedures have definitions of restraints and enablers in line with the standard. Staff demonstrated good knowledge about restraints and enablers.
<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>	FA	<p>Systems are in place for determining the restraint approval processes. The restraint coordinator and staff interviewed and the resident's file evidenced responsibilities were identified and known. The resident's file of the one person using a restraint evidenced the resident and family input into the restraint approval processes. There was a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The approval group forms part of the quality meetings and discussion includes education and competencies, equipment, and the use of restraint.</p> <p>Care staff interviewed were aware of the restraint co-ordinator's responsibilities. Policy/procedures define approved restraints and alternatives to restraint with strategies to minimise the use of restraint and management of challenging behaviour. The orientation/induction programme includes overview of restraint policies/procedures.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Systems are in place that ensure assessments of residents are undertaken prior to restraint usage being implemented. The resident's file demonstrated restraint assessment and risk processes were being followed. The assessment is based on the standard.</p> <p>The resident's file evidenced restraint assessment risks were documented and included resident and/or family input. The care plan evidenced restraint assessment risks were reviewed. Care staff demonstrated a sound knowledge concerning restraint procedures.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Appropriate systems ensure the service is using restraint safely. The restraint policies and procedures identify risk processes that are to be followed when a resident is being restrained. The resident's file evidenced evaluations, review of restraint goals and interventions that were current.</p> <p>The one resident's file reviewed demonstrated appropriate alternative interventions were implemented and de-escalation attempted prior to initiating restraint. The restraint consent by resident and the family was current. The restraint register is current and provided sufficient information.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes</p>	FA	<p>The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The resident's file reviewed evidenced each episode of restraint is monitored. Restraint use is evaluated</p>

of restraint.		three monthly, and the form used is based on the standard. Restraint is included in the quality, RN and staff meetings.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint is reviewed monthly by the quality/education coordinator and entered into an electronic restraint/enabler analysis report. Restraint and enabler use is reported to the FM monthly by the quality/education coordinator. Audits of restraint are included in the audit programme. Policies and procedures include monitoring and quality review processes. Staff have received education relating to restraints and enablers and restraint competencies were current.

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>Masonic Court in conjunction with the local hospice has implemented the supportive education and quality palliative care(SEQUAL) programme. The objective was to ensure primary palliative care and the palliative approach to residential care is delivered, measurable and sustainable. The vision is that ‘all people with life limiting conditions live well and die well irrespective of their condition or care setting’.</p> <p>Although palliative care was being provided, it was inconsistent. Staff had varying degrees of knowledge and comfort relating to the topic. Families had identified verbally that they would have liked more time to consider options and plan in the event of end of life and wanted to know what to expect.</p> <p>Staff were consulted and agreed to undertake the programme and training with six weekly meetings on site lead by hospice staff.</p> <p>The hospice team completed a documentation review pre and post project. Post project showed improvement in all measurable areas of</p>	<p>The project has facilitated improved end of life outcomes for residents and their families with support from the local hospice and the facility’s GPs. Residents to date have not been transferred to the DHB hospital. Family feedback has been very positive with reports that the enhanced approach to end of life care has made a difference in understanding the processes involved. Staff have a better understanding of the palliative approach to care and stated they are more confident and comfortable with initiating end of life care and discussing this with residents and their families.</p>

		<p>documentation; showing anticipatory medications being charted, advance care plan discussions occurring, and no transfers to hospital for end of life (EOL) management. A palliative approach to care (PAC) has been incorporated into documentation and includes quality targets. The PAC philosophy links with the Te Whare Tapa Whā philosophy.</p> <p>Evaluation of the project resulted in the end of life wishes documented in residents' files, 100% of anticipated deaths having an end of life care plan in place, anticipatory conversations taking place in a supported environment with GPs involved as required, anticipatory medications charted for symptom management, so the need for transfer to a DHB hospital is not required. A family survey was developed that is sent out three months post death. Surveys received showed very positive results indicating the changed approach to end of life care has made a difference. Interviews with the FM, staff, nurse practitioners and a hospice RN confirmed this. A staff survey by SEQUAL indicated gains in confidence with care and conversations. Strong working relationships have developed with the local hospice and the facility's GPs.</p>	
<p>Criterion 1.3.3.4</p> <p>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>Systems are in place at Masonic to promote continuity of care, such as detailed progress notes, a verbal handover at the start of each shift, and written handover sheets, however lack of afterhours medical coverage was compromising continuity of care.</p> <p>Masonic offers all residents a choice of who to use as a GP. Nearly all residents choose to remain with their own GP. This has resulted in Masonic being serviced by 29 different GPs. Most of those GPs provided no access to afterhours services, resulting in Masonic staff having to send residents to the MidCentral DHB (MCDHB) for attention to medical issues that could have been managed at Masonic if a GP or NP was available. Between August 2018-February 2019 there were 25 admissions to the MCDHB, and 18 of these could have been managed at Masonic if a GP or NP was available.</p> <p>All GPs/NPs caring for residents at Masonic were contacted by the FM to clarify with them the arrangements they have for afterhours cover. This information was then collated into a single document held at Masonic which identifies each GP's afterhours arrangement and</p>	<p>An initiative to ensure GP/NP services can be accessed after hours by Masonic has resulted in no unnecessary admissions to the MCDHB since February-2019.</p>

		<p>processes, and whom to contact if afterhours services are required. The Elder Health Team has been involved in assisting with clarification of afterhours arrangements. Clear guidelines are now in place. This has resulted in no unnecessary admissions to the MDHB since February 2019.</p>	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>CI</p>	<p>An analysis of falls data between January and March 2019, identified that, of the 29 falls in the rest home, 21 of those were on a Thursday, Saturday or Sunday morning. A review of the care planning system identified on these days there was a greater number of residents requesting showers than on the other four days. All these falls involved seven residents. A review of staffing levels and the staff on those duties could not be identified as a contributing factor. An analysis of the data identified the falls related to activities preceding the shower or within a short time after, mainly toileting or dressing activities.</p> <p>As a result of this finding, the number of showers in the morning on Thursday, Saturday and Sunday morning was reduced. A resident passport was developed, and an individualised showering regime was developed, that details days and times of showers. Shower times were allocated in the passport so residents could 'plan' and were not put in a position of not knowing what time they would have their shower and having to rush at the last minute. The regime reduced the high number of showers at one time, minimising the number of staff occupied with resident showers and unable to answer bells.</p> <p>Between April and June 2019, total falls in the rest home was reduced to eight. Only two of the seven 'high risk fallers' noted in the January-March results had falls. The falls related to one-off accidents, that were being managed on an individual basis. Feedback from residents was positive around feeling in control of when they have their shower and the time they can have them. Residents do not feel rushed. Care staff have more time to attend to residents and can plan, and shower residents at the time noted in the passport as the number of showers are reduced in the morning.</p>	<p>An analysis of falls data, has identified that a change in the care planning regime has reduced the incidents of falls in the rest home at Masonic.</p>

End of the report.