

Ropata Lodge Limited - Ropata Lodge

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:	Ropata Lodge Limited
Premises audited:	Ropata Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 August 2019 End date: 28 August 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:	31

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

Ropata Lodge is an aged care facility in Lower Hutt that provides rest home level care for up to 35 residents. The service is privately owned and managed by a facility manager. Reports about the care and support provided and management of the service were all positive.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the local district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, a contracted allied health provider and a general practitioner.

There were no areas identified as requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.	Green	Standards applicable to this service fully attained.
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The facility manager provides residents and family members with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected.

Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Systems are in place to ensure residents who identify as Māori have their needs met in a manner that respects their personal cultural values and beliefs. There was no evidence of any form of abuse, neglect, discrimination or exploitation.

Open communication between staff, residents and families is promoted, there is access to interpreting services if required and strategies are put into place to support people with compromised communication abilities. Residents and family members are provided with the information they need to make informed choices and to give various forms of consent.

The service has linkages with a range of community based and specialist health care providers to support best practice and meet the needs of each resident.

There have been no complaints within the facility, but a process is in place to manage these should they occur. Complaints forms and advocacy information is readily available throughout the facility and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The business plan includes the mission, scope, direction, and goals of the organisation. Quality and risk management plans are in place and they include collection and analysis of quality improvement data, identifying trends and leading to improvement. Staff interviewed confirmed that they were involved in quality and risk management and monitoring.

Services monitoring information is provided to the facility owner. It was regular and effective and included quality indicators and risk management information. An experienced and suitably qualified registered nurse manages the facility with support from another registered nurse and health care assistants.

Adverse events are documented, monitored and corrective actions are implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery; they were current and regularly reviewed.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Staff undergo regular individual performance review. Staffing levels and skill mix meet the needs of the residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Relevant information is provided to prospective residents and their families in response to enquiries about the service. Entry processes to the facility are appropriately and efficiently managed.

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

A variety of individual and group activities that include opportunities to link with the community and pursue personal preferences are available within the planned activity programme.

Safe practices are in place for the management of medicines. All staff responsible for any aspect of medicine management have been assessed as competent.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. Food is safely managed according to a food control plan. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and maintained. There was a current building warrant of fitness. Electrical equipment is tested annually. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances were well managed. Staff use protective equipment and clothing, and this is easily available throughout the facility. Chemicals, soiled linen and equipment were safely stored. Personal laundry for residents is undertaken on-site and evaluated for effectiveness through the internal audit processes. Other laundry (bedlinen and towels) is sent off-site to a contracted provider. Returned laundry was sighted and observed to be clean and tidy.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are practised. Call bells are available in all residents' rooms and in communal areas. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has policies and procedures that support the minimisation of restraint. Whilst there were no restraints used in the facility, there is a process in place which would allow for assessment, approval, monitoring, and review, if required. Medical personnel would be involved in the restraint approval process should this be required.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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An infection prevention and control programme that aims to prevent and manage infections is underpinned by relevant policies and procedures. Implementation of the programme is led by a trained infection control officer. Specialist infection prevention and control advice is accessible when needed.

Staff described and demonstrated good principles and practices around infection control, which is supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Organisational policies, procedures and processes meet Ropata Lodge's 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 encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the new staff orientation process and listed in the mandatory topics of the ongoing staff training programme. Residents and family reported staff consistently communicate with them in a respectful manner.
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 show that informed consent has been gained appropriately using the organisation's standard consent form. This covered use of photographs, management of personal information, outings and medical care. Advance care directives, decisions around resuscitation, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care and residents confirmed staff give them choices and uphold their decisions. These practices were also observed.

<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>An information pack provided to new residents and family/whānau during the admission process includes a copy of the Code, as well as information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Residents spoken with were aware of the nationwide advocacy service, while others said they had probably been told but they could not specifically recall it as they were told so much. A person from the local Advocacy Service has visited the service and informed residents about how to access this service and their right to have support persons. The manager could not recall any specific example of the involvement of Advocacy Services, but described how residents talk to a resident advocate associated with the service. Information about this role and such opportunities were on the noticeboard.</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. Other community resources being used include the local hospice, the Deaf Association, Age Concern, district nurses and the Anglican church residents' advocate.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. The doors close at 4.30pm for residents' security as the front door is on a main street; however, there is a doorbell for visitors' use.</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 management process is clearly described in the policy document and includes information on the Office of the Health and Disability Commissioner and a complaints flowchart. Advocacy and staff education on complaints management are included in the policy. The documented procedures are clear and meet the requirements of this standard, the provider's contract with the DHB and Right 10 of the Code. Information on the complaint process and available advocacy is provided to residents and families through the admission agreement and on entry to the service. Complaints and advocacy information is available within the facility.</p> <p>There were no complaints recorded by the facility since the previous audit. Should there be complaints, the sighted complaints register contained sufficient detail about complaints (eg, dates, descriptions, investigations, and outcomes). Action planning is in place through the corrective action processes of the facility. The manager is responsible for complaints management and follow up.</p> <p>Staff are informed about the complaints process during induction and, if there were complaints, there is a process by which they would be reported to staff at staff meetings. All staff interviewed understood the</p>

		<p>complaint process and the actions required to manage a complaint and that any complaint would also be reported through the quality control reporting system.</p> <p>Relatives interviewed confirmed they were informed about the complaints system and would have no hesitation in raising concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The manager informed that the Code is discussed with residents and family members present at the time of a resident's admission. Information about the Nationwide Health and Disability Advocacy Service (Advocacy Service) is also provided. Additional copies of brochures on the advocacy service, the Code, how to make a complaint and copies of the concerns and complaint forms are available at the reception desk. Residents interviewed were aware of the principles of the Code and described what they would do if these were breached. The Code is displayed in English and te reo Maori near the front entrance.</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 described things that happen, and activities they pursue, that confirmed they receive services in a manner that has regard for their dignity, sexuality, spirituality and choices. The importance of family/whānau was noted.</p> <p>A policy on privacy covers physical and auditory aspects as well as personal records and information. The privacy officer is the manager. All residents have a private room and their own telephone. Staff were observed to maintain privacy throughout the audit and residents informed that their privacy is always respected.</p> <p>Residents are encouraged to maintain their independence by participating in activities, walking as much as possible, involving themselves in community activities and pursuing their lifelong interests. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented into a social assessment profile and incorporated into their care plan as relevant.</p> <p>Staff understood the service provider's policies and guidelines on elder abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Residents and family interviewed had not seen or heard of any incident of an abusive nature.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are described in organisational policies and procedures and incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers and 'te whare tapa wha' is described as a perspective of Māori health. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. One of the staff blesses rooms as necessary and is able to contact the local marae for any additional information or support. At the time of audit there was one person who identified as Māori. Family/whānau were quite clear about the level of cultural involvement preferred and this is respected.</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>A policy on culturally safe practice was sighted and encourages staff to examine their own identity and the concept of working in partnership. Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Personal preferences, required interventions and the special needs of each resident were included in care plans reviewed. The resident satisfaction survey confirmed that their values and beliefs are respected, and 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 members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. New staff are also required to sign a copy of the house rules, which cover 24 related factors that include conduct, the signing of legal documents and the organisation's philosophy. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The manager reported that the primary aim is for good quality of care for residents. The service encourages and promotes good practice through implementing referenced evidence-based policies and adopting updated accepted best practices. Input from external specialist services and allied health professionals is sought and utilised as required with examples being local district nurses for wound care, the hospice/palliative care team and mental health services for older persons. During interview with the main house general practitioner (GP), it was confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support for internally provided training sessions and are</p>

		<p>encouraged to undertake appropriate external education that supports contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the manner in which the manager is starting to use data to guide decisions about managing a falls prevention programme and the use of feedback and consultation processes from families to contribute towards services delivered.</p>
<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 stated they were kept well informed about any changes to their status. Family interviewed informed they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the communication recording sheets and progress notes in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>An interpreter and translation policy and procedure described how staff may access interpreter services and those interviewed were aware of how to do this. Staff members and family have been used to assist with communication in the past; however, there is not currently any person requiring such services. The manager described how staff are educated and encouraged to ensure residents requiring hearing aids have these needs attended to and that specialist advice is sought when required. A range of strategies that assist communication with a person who has both a hearing and a visual impairment are in place.</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>The business plan is reviewed annually and includes the mission, scope, direction, and goals of the organisation. Quality and risk management, vision and mission statements are documented and reviewed as part of the business planning process. A sample of the reports provided to the owner of the facility showed adequate information is given to enable performance monitoring. Progress against goals is monitored by the facility manager and reported weekly. Outcomes from these meetings are documented and showed that all areas of service provision are discussed.</p> <p>The service is managed by a manager who is a registered nurse; she has been in post for almost five years. The manager was able to describe knowledge of the sector, regulatory and reporting requirements and maintains currency through the DHB updates and aged residential care forums. The manager is on site five days a week and on-call after hours. Records showed that the manager is attending education appropriate to her role. Family members interviewed confirmed their satisfaction with all areas of service delivery and the ways in which their relative's needs are being met.</p> <p>The service holds contracts with the Hutt Valley DHB. Thirty-one residents were receiving services at the time of audit. Ropata Lodge has contracts to provide rest home care under the Aged Related Residential Care Agreement (ARRC) and may take respite care residents and residents on the long-term services chronic health conditions (LTS-CHC) contract depending on the level of care required.</p>

		On the day of audit one person was under the contract and the remaining 30 were under ARRC for rest home care
<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>During any absence of the manager, clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. The facility owner takes responsibility for non-clinical matters with the assistance of the facility administrator. Staff reported the current arrangements work well and that they felt supported by the facility manager, the owner, and registered nurse.</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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement and is understood and implemented by staff. This includes an annual audit schedule, a resident and a staff satisfaction survey, complaints, hazards, and clinical incidents including infections and other incidents/accidents. The most recent resident and staff survey feedback showed that most respondents were either satisfied or very satisfied with the services/support provided at the facility.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at quality and staff meetings. The quality control committee is responsible for setting annual quality, infection control, and health and safety goals and measures. Data produced by review of the monthly surveillance/quality systems is conveyed to the facility owner and Ropata Lodge staff through reports and regular staff meetings.</p> <p>Staff reported their involvement in quality and risk management activities through the staff meetings, audit feedback, and incident/accident trend analysis activities. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, were based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. All controlled system documents are identified with the document title, revision number, issue number, date and page number. Formal authorisation of documentation is identified on the System Index that identifies and authorises all current documentation issued. The system includes keeping policies and procedures updated, conducting regular internal audits, reporting incident/accident and health and safety matters, review of restraint (if this had been in use), infection control data and</p>

		<p>complaints management. The manager is responsible for controlled document review.</p> <p>The manager was able to describe the processes for the identification, monitoring, review and reporting of risks and the development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented its requirements.</p> <p>Corrective actions from the audit process are implemented when there are service deficits. All reporting is linked to management processes through the manager's weekly reports to the owner of the facility and to staff via staff meetings. This information is used to inform ongoing planning of services to ensure residents' needs are met.</p> <p>The service wide approach to risk management includes analysing incident reports, hazards, and other checks (through the audit process) to identify and communicate ongoing risk. Staff are being kept updated about any actual or potential risks by the manager, through care planning activities and via handovers. This was confirmed in meeting minutes sighted and verified by staff interview. Quality indices (eg, falls, infections) are benchmarked internally with hospital admissions benchmarked through the DHB against other facilities in the area.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The facility has an accident and incident policy which notes the need to comply with health and safety legislation. All adverse, unplanned or untoward events are systematically recorded, investigated and analysed and the need to notify appropriate statutory agencies of essential information is included. Staff document adverse and near miss events on an incident/accident form. The manager collates all incidents monthly according to the number and type of incidents/accidents and notes where and when these occur and if the incidents related to people, processes, or the environment.</p> <p>A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and any corrective action followed-up in a timely manner. Detail of disclosure to families was evident on the forms as well as input from the resident's GP where this was applicable. Adverse event data is collated, analysed and reported to the facility owner, to the staff at staff and quality control meetings, and with graphed trends available to staff in the staff rooms.</p> <p>The manager was able to describe essential notification reporting requirements, including for pressure injuries. There have been no notifications of significant events made to the Ministry of Health or other parties since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Review of human resource management policies and procedures, six personnel records, and interviews with staff and the manager revealed good employment processes and concordance with relevant legislation. The recruitment process includes interviewing, referee checking, police vetting, and</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Job descriptions for multiple roles including for Privacy Officer, Fire Safety Officer, Civil Defence Officer, Restraint/Enabler Officer and Education Coordinator were sighted.</p> <p>Employment agreements and evidence of ongoing supervision (performance appraisal) was evident in all files sighted. A spreadsheet was available (and sighted) which documented education delivery to staff.</p> <p>Staff orientation includes all necessary components relevant to the role including introduction to the facility's house rules (code of conduct). The staff files and interviews with care staff confirmed that orientation is planned, coordinated and effective. Orientation initially includes a series of practical and theoretical teaching sessions with follow up competency tests and questionnaires. Once the initial orientation is completed the new employee works with a 'buddy' for a period of time until they are competent to work independently Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation over a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have the opportunity to pursue a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Certificates sighted confirmed this.</p> <p>Each staff file contained a signed employment agreement, job description, evidence of police vetting, referee checks and a dated and signed orientation programme. The staff files of the RNs showed that the RNs have a current annual practising certificate (APC). The manager verified that other registered health practitioners are authorised to practice before allowing them to provide services. APCs for associated health professionals (GP, pharmacy and podiatry) were current and on file.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery (guided by the MoH safe aged care staffing guidelines), 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet changes in the resident's needs. The manager is on site Monday-Friday during the day and on-call afterhours. At least two caregivers are rostered for every duty (one of which is a senior caregiver) and staff reported that there is good access to advice available to them when needed. Care staff reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and family interviewed reported that they were happy with the level of service provided. Activities, kitchen, and domestic staff are allocated sufficient hours to provide services. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At</p>

		least one staff member on duty has a current first aid certificate.
<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>Policies and procedures on the management of health information are well referenced and consistent with current relevant legislation All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information that had been entered into the Momentum electronic database. Records were legible with the signature and designation of the person making the entry identifiable.</p> <p>Archived records of current residents are held in a filing cabinet in the manager's office. A secure off-site storage container that is managed by an external contractor holds older records that were reported as being easy to access and retrievable when needed.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service as suitable for the services provided at Ropata Lodge. The NASC team is kept informed about vacancies and changes in service provision. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process in a pre-admission pack.</p> <p>Residents and a family member interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer processes are managed in a planned and co-ordinated manner. There is open communication between all services, the resident and the family/whānau. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. All transfers are documented in the progress notes.</p> <p>The manager/registered nurse described actions taken when there are indications that a resident might need to transition from Ropata Lodge to residential hospital level care. Such indications might include an increase in the frequency of the person falling, multiple GP reviews needed or if the person requires two people to assist them with personal cares or transfers. Family and the resident are involved</p>

		throughout the process. The interRAI is reviewed, the NASC is asked to reassess the person's needs and older persons' rehabilitation services are involved. Appropriate information is provided to the next facility for the ongoing management of the resident.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management based on hard copy medication charts 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 were competent to perform the function they managed, and all medicine management competencies were current. Specimen signatures are at the front of the front of the medicine chart folder and on each signing sheet.</p> <p>Medications are supplied to the facility in a pre-packaged robotic roll from a contracted pharmacy. A registered nurse checks the medications against the prescription. All medications sighted were stored safely and were within current use by dates. Only a senior healthcare assistant or the registered nurse may hold the keys to the medicine storage area. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly checks and entries were accurate.</p> <p>The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Good prescribing practices noted the date recorded on the commencement and discontinuation of medicines on the medicine charts. All requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review was consistently recorded on the medicine record. There are no standing orders used in this facility.</p> <p>At the time of audit two residents were self-administering their inhalers. Appropriate processes were in place to ensure residents' self-medication processes are managed in a safe manner.</p> <p>There is an implemented process within the incident reporting system for comprehensive analysis of any medication errors.</p>
Standard 1.3.13: Nutrition, Safe	FA	Food services are provided on site by a qualified chef and kitchen team and are in line with recognised nutritional guidelines for older people. The chef and a kitchen hand were interviewed during the audit.

<p>Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>To ensure variety, the menu changes with each of the four seasons of summer, autumn, winter and spring and has four-week rotational patterns. The menu has been reviewed by a qualified dietitian within the last two years with the most recent in February 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council for one year, expiring 9 August 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan as are kitchen cleaning schedules. The food services manager has undertaken a safe food handling qualification, with kitchen assistants also having completed 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. Kitchen staff are alert to allergies and the chef described how he ensures the safety of these residents.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction survey results and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion.</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>	<p>FA</p>	<p>The manager informed that to date there has not been a need to decline entry to the service, although an example was provided of a person being too unwell to be cared for in this facility and was returned to hospital before admission. It was explained that if a referral was received but the prospective resident did not meet the entry criteria or there was no vacancy, the local NASC would be advised to ensure the prospective resident and family were supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>New residents are required to have an interRAI assessment prior to admission and a copy of this is requested by the service provider. Information from this and from initial interviews with the resident and family is used to assist with the initial nursing care plan. Other assessment processes include a nutritional assessment, a social assessment and a medical assessment by the GP. The sample of care plans reviewed had an integrated range of resident-related information based on initial and ongoing reassessment processes. All residents had a current interRAI assessment completed by one of the two</p>

		trained interRAI assessors on site. Residents and a family member confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and a family member reported participation in the development and ongoing evaluation of care plans. Service delivery plans were consistent with the needs of residents requiring rest home level care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care 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 GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and there were no concerns about the care interventions provided. Healthcare assistants confirmed that care was provided as outlined in the residents' documentation. A range of equipment and resources applicable to rest home level care was available.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a part time activities co-ordinator who has complete the equivalent of level three of a national certificate. A volunteer and some of the healthcare assistants further support the programme.</p> <p>On admission, a social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities described in monthly schedules that were sighted reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review. Daily participation records are maintained, and monthly summaries of each resident's involvement are documented.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys and multi-disciplinary meetings. Those interviewed confirmed</p>

		they find the programme excellent and said there is always something to do. A table of activities people may spontaneously try includes table games, colouring in and crosswords for example.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse who takes appropriate actions. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being developed, reviewed and progress evaluated as clinically indicated were noted for infections and wounds. These included photographs of the healing process for wounds. When necessary, and for unresolved problems, long term care plans are added to and updated accordingly. Examples of this having occurred were sighted. Residents and a family member interviewed provided examples of involvement in evaluation of progress.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to ophthalmologists, dermatologists and the orthopaedic clinic. Family/whānau are encouraged to take residents to these appointments; however, the service provider will assist if this is not possible. Records of specialists' consultation letters were in residents' files. Other key health and disability providers include older person's rehabilitation services the district nurses and a podiatrist, who visits monthly.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in policy, as is storage and use of chemicals. Staff follow documented processes for the management of waste and infectious and hazardous substances. Care and domestic staff interviewed demonstrated awareness of safety issues around managing waste and hazardous substances. Two spills kits are available for use in an emergency and are conveniently located for access when needed. An external company is contracted to supply and manage chemicals and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this. Body waste and continence products were observed being disposed of with staff wearing

		appropriate personal protective equipment (disposable aprons and gloves).
<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 interior and exterior of the facility is maintained and is fit for purpose. A current building warrant of fitness (expiry date 25 March 2020) was publicly displayed. There is access for residents to outdoor gardens with a number of recreational areas including for those who use mobility support equipment. The environment was hazard free to promote residents' safety and independence. There have been no incidents or accidents related to the external environment. The front door is secured in the evenings and through the night with access available through a night bell call system.</p> <p>Corridors, toilets and shared bathrooms have appropriately installed handrails. Residents' rooms have ensembles.</p> <p>There is one hoist on site and records showed that this has been checked annually. Electrical testing and tagging is completed by a certified electrician annually (records sighted). All fire safety equipment is checked monthly by an external service agency. Calibrations of scales and medical equipment occurs annually, and records showed this occurred on 22 August 2019. Audit documents reviewed confirmed that environmental inspections occur bi-annually, and maintenance requests are attended to as soon as possible.</p> <p>There was evidence that hazards are reported. Visual inspection revealed that external areas are safe and meet the needs of the resident group. Seating is safe and suitable for older people. Shade is available to allow for sufficient shade for sitting outdoors in the summer.</p> <p>The transportation of resident's policy contains fully described and detailed information which is directly related to the safe transporting of residents. Some residents are independent and able to manage off-site activities themselves. Where this is not possible, they are accompanied either in the care of their family, or with one of the facility staff members present.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with</p>	FA	<p>The facility has a good number of easily accessible toilets and showers. Each room has an ensuite containing a toilet, handbasin and shower. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Communal toilet facilities are available, and these are large enough to be accessible for residents with mobility aids and/or wheelchairs. There are designated staff and visitor toilet areas. Observation confirmed that residents' privacy was respected by staff when accompanying residents to attend to their personal hygiene needs. Staff interviewed understood the obligations to provide privacy and promote dignity during care activities.</p> <p>Hot water areas accessed by residents were tested weekly to ensure water is delivered at a safe</p>

personal hygiene requirements.		temperature. Water temperature records showed no temperatures over 43 degrees. The manager was able to describe a process to ameliorate any variances that may occur through changes to the thermostatic control of the water by a contracted plumber.
<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>Good personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single or shared accommodation and are very generously sized. As well as a bedroom area, all rooms have a sitting area and space for the use of small kitchen appliances. Rooms are personalised with furnishings, photos and other personal items and there is storage in each room for personal clothing. The beds and bed linen are being continually updated and observation of the linen being used showed it to be in very good condition.</p> <p>There is room to store mobility aids and wheelchairs within the residents' rooms and communal areas.</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>Residents at Ropata Lodge have access to an internal garden area. The home is spacious with internal and external walking areas for residents. Residents were observed walking freely throughout the facility and a lift is available for transfer between floors. The lift is serviced regularly by an external contractor. There are a number of recreational and dining areas for residents. The dining and lounge areas are spacious and enable easy access for residents and staff, including for residents using mobility aids. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policies and procedures include job descriptions, and scheduled tasks are clearly described and known to staff. Personal laundry for residents is undertaken on-site in a dedicated laundry area. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. General linen (bedlinen and towels) is laundered off-site. Interviews with staff demonstrated that efficient and effective systems are in place for cleaning and laundry. All areas in the home were observed to be clean and hygienic. Relatives expressed satisfaction with the services provided. Chemical training was evident in staff files. Chemicals were in a secure area and stored in a lockable cupboard. Chemicals were observed to be in appropriately labelled containers and safety data sheets were adjacent to the chemical storage area.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the latest satisfaction survey indicated that satisfaction levels were good or very good.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The emergency supplies available meet the requirements of the Ministry of Civil Defence and Emergency Management. The fire and emergency procedures manual sighted includes an evacuation plan and procedure outlining the responsibilities and duties of staff, fire equipment available and the requirements for trial evacuations, staff training and orientation, inspections and principles of fire alarms. A separate emergency procedures manual covers emergency planning, disaster preparedness, planned and emergency evacuation. The document also includes a full series of external emergency procedures (e.g. gas leak, bomb threat, sewerage failure), along with civil defence supply checking and signing.</p> <p>A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 17 July 2019. Fire suppression systems are checked monthly by an external service. The orientation programme includes fire safety education and training. Staff confirmed their awareness of the emergency procedures and what they need to do in the event of a fire. The RNs and senior care staff have current first aid certificates (two are awaiting refresher training to take place in September).</p> <p>Adequate supplies are available for use in the event of a civil defence emergency, including food, water, blankets, lighting, mobile phones and gas cooking facilities to meet the requirements for residents. A large water storage tank is located in the grounds of the facility. Emergency lighting is tested regularly.</p> <p>Call bells to alert staff to residents requiring assistance are accessible and within easy reach. During the audit staff were observed to be attentive to the needs of the residents. There were few call bells heard during the audit and these were responded to promptly.</p> <p>Appropriate security arrangements are in place. Exit doors and windows are checked in the evening and the external door (to the street) is locked in the evening and overnight. Access into the building at these times is via an external call bell. Staff say any security incidents would be reported to the manager of the facility (there have been none).</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Communal areas have doors that open onto an outside garden area. Heating is provided in residents' rooms in the communal areas, controlled by thermostat. Areas were observed to be warm and well ventilated throughout the audit. Family members interviewed stated the home is maintained at a safe and comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provider implements an infection prevention and control programme that is intended to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, which has been developed with input from infection control specialists. Ongoing reviews of the infection control programme and manual are occurring as required.</p> <p>The facility manager/registered nurse is the designated infection prevention and control officer. The role and responsibilities are defined in the infection prevention and control documentation. Infection control matters, including surveillance results are tabled at the quality improvement committee meetings. This committee includes the facility manager, a second registered nurse, a senior healthcare assistant, the activity coordinator and representatives from food services and household management.</p> <p>Staff are advised not to go on duty if they are unwell or have been unwell in the past 48 hours. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. The manager informed there has not been a problem with visitors going into the facility when unwell. A laminated sign is available for use should an outbreak occur. Hand sanitiser is available at the reception desk beside the visitor and contractor sign-in books as well as being easily accessible in dispensers around the facility.</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 prevention and control officer has appropriate skills, knowledge and qualifications for the role. In addition to attendance at relevant training sessions, verification of completion of more advanced infection prevention and control training was sighted. Additional support and information are available from the facility GP and through a local DHB contact person. The infection prevention and control officer has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control officer confirmed the availability of resources to support the programme and described actions that would be undertaken and who might be accessed for additional advice for any outbreak of an infection. This has not been necessary under the current manager's employment.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2018 and included appropriate referencing.</p> <p>Healthcare assistants, cleaning 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</p>

<p>accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices and described processes of everyday practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection control officer with the last completed in July of this year. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</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 cough etiquette.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin and soft tissue, eye, gastro-intestinal, multi-resistant organisms and the upper and lower respiratory tract. All infections are documented on a relevant infection report form and each is reviewed by a registered nurse and/or the infection prevention and control officer. Medical advice is sought as appropriate. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection prevention and control officer records data about any infections on a monthly infection report form and develops linear graphs with each type of infection identifiable. From these records and graphs, monthly surveillance data is analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings. Further graphs are produced that identify trends for the current year. Corrective actions are implemented as identified. Staff confirmed during interview that the graphs now used by the infection control officer to record infections has made it easier for them to understand the infection surveillance reports.</p> <p>There have been no infection outbreaks other than a series of coughs and colds in early winter.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints. Processes for assessment, approval and consent,</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>monitoring and review, evaluation, cultural considerations, de-escalation and staff training were clearly described.</p> <p>Restraints and enablers are not used in the facility and there was no intention to introduce their use at the present time. The restraint coordinator (who is the manager) would provide support and oversight for restraint management in the facility if restraint was to be used.</p> <p>The manager demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities and the facility has a well described policy on understanding and managing challenging/difficult behaviour.</p> <p>Education on restraint and challenging behaviour was evident from the orientation records of the staff files sighted.</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.