

Maygrove Care Limited - Maygrove Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Maygrove Care Limited

Premises audited: Maygrove Village

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 6 November 2019 End date: 7 November 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: 50

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
	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
	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

Maygrove Village Hospital provides rest home and hospital level care for up to 50 residents. The service is operated by Maygrove Care Limited and managed by a general manager, manager and clinical manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Waitemata District Health Board (WDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and two general practitioners.

The audit has resulted in a continuous improvement in safe and appropriate environment. There were no areas 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.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. Access to interpreting services is provided if required. Staff provide residents and families with the information they need to make informed choices and give consent. Services are provided in a manner that respects residents' cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A business and quality and risk plans include the goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are very involved and feedback is sought from residents and families. Adverse events are documented with corrective action implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and is 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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Maygrove village hospital's entry into the service is appropriate and efficiently managed with relevant information provided to the potential resident/family. Admission assessments are completed by qualified staff including the general practitioners (GPs). All residents have current interRAI assessments. 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 were reviewed and evaluated on a regular and timely basis. Residents were referred or transferred to other health services as required.

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

Medicines are safely managed and all staff who administer medicines have current medication administration competencies.

The food service is provided by the village kitchen and meets the nutritional needs of the residents with special needs catered for. A current food safety plan is in place and food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

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

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. Residents are taken to the external areas by staff or family as the hospital is on the first floor of the building. Shade and seating is available in the grounds.

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

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire training and fire drills. Residents reported a timely response to call bells. Security is arranged and 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.

Maygrove Village Hospital has implemented policies and procedures that support the minimisation of restraint. Six enablers and ten restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews

occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler process.

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

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

Aged care specific infection surveillance is undertaken and results reported through all levels of the organisation. Follow-up action was completed as and when required. There has been no infection outbreak since the last audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Maygrove village hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy during provision of care. Interviewed staff understood the requirements of the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>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. There were residents with advance care planning in place. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons of their choice. Interviewed staff provided examples of the involvement of Advocacy Services in relation to residents' meetings.</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. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that eight complaints have been received over the past year and that actions were taken through to an agreed resolution and were documented and completed within the timeframes required. Action plans showed any required follow up and improvements have been made where possible. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaints process and what actions are required. One external complaint from September 2018 was closed out on the 13 May 2019 by the Health and Disability Commissioner's office (HDC) as being unsubstantiated.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code is displayed at the reception and on notice boards together with information on advocacy services, how to make a complaint and feedback forms. Interviewed staff reported that explanation and clarification on the Code is provided to the residents, family and/or their legal representative on admission to the facility. The Code and information about the Nationwide Health and Disability Advocacy services (Advocacy Services) are provided as part of the admission pack. Interviewed residents and family confirmed being made aware of the Code and advocacy services as part of the admission process.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Interviewed residents reported that they can arrange their own external visits if desired. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Training records were sighted. Interviewed residents, family members and GPs reported there has been no incidents of abuse nor neglect alleged or suspected reported.</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 have received training on tikanga and Maori health. Interviewed staff demonstrated knowledge on how to support residents who identify as Māori to integrate their cultural values and beliefs. There were no residents who identified as Maori on the days of the audit. The staff understood the principles of the Treaty of Waitangi and how to incorporate them into day to day practice, and the importance of whānau. Guidance on tikanga best practice is available and accessible to staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey records sighted confirmed that individual needs are being met. Staff have received training in cultural sensitivity; training records were sighted.</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. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the 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 service 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, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The annual education plan sighted included all mandatory education sessions and these were completed as per schedule. The interviewed general practitioners (GPs) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. External education certificates were sighted.</p> <p>Other examples of good practice observed during the audit included comments from the paramedics who had transferred a resident back to the facility, that the service responds promptly and has good processes in place for smooth transfer of residents to and from the facility. They reported that the service provides appropriate documentation and handover to the paramedics.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed and was confirmed by interviewed residents and family members. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Completed accident and incident forms evidenced involvement of the resident and family in the reporting process.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English and communication boards for those with communication difficulties. On the days of the audit staff were observed communicating with a resident with communication difficulties using a communication board.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The quality and business plan for Maygrove Village Hospital was reviewed in 2019. Quality and risk planning is clearly documented with goals and objectives covering a resident focus on service delivery, provision of effective programmes, meeting certification and contractual requirements, quality and risk management and continuous improvement. The organisation's mission statement and philosophy were documented along with the values. A sample of monthly reports to management included if there were any emerging risks and/or issues. The general manager operations was present for the closing meeting of the audit.</p> <p>The service is managed by a manager who holds relevant qualifications and has been in the role for nearly five years. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The manager is a registered nurse and confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through the DHB management and leadership programme, hospice education, conferences and other relevant study days which was verified.</p> <p>The service holds contracts with Waitemata District Health Board (WDHB) for rest home, hospital and respite level care for up to 50 residents. On the day of audit there were two rest home residents and 48 hospital level care residents. One of the hospital level care residents has been recently re-assessed as requiring psycho-geriatric care. The resident is awaiting placement and is currently being closely monitored by the mental health team and staff. The DHB portfolio manager has been informed.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the manager is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff the clinical management is overseen by the manager. The manager is a registered nurse and is able to take responsibility for any clinical issues that may arise. Staff interviewed reported that the current arrangement works well.</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</p>	<p>FA</p>	<p>Maygrove Village Hospital has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of complaints, incident and accidents/adverse events, monitoring of outcomes, annual satisfaction surveys, clinical incidents including infection prevention and control and restraint minimisation.</p> <p>Meeting minutes reviewed confirmed that regular review and analysis of quality indicators and that related information is reported and discussed at the quality meetings and staff meetings. Staff reported their</p>

<p>reflects continuous quality improvement principles.</p>		<p>involvement in quality and risk management activities through audit activities and being part of various committees, for example, the health and safety, infection prevention and control and restraint minimisation committees. The lists were displayed in the staff room and office. Relevant corrective actions are developed and implemented to address any shortfalls. Resident, family and staff satisfaction surveys are completed annually. The most recent survey evidenced positive feedback was received and any identified issues were addressed.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are 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.</p> <p>The manager described the processes for identification, monitoring, review and reporting of any risks and development of mitigation strategies. The manager and the health and safety representative also interviewed had a good understanding of the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions follow-up in a timely manner. Adverse event data is collated, analysed and reported to the general manager operations by the manager. The manager described essential notification reporting requirements including for pressure injuries. The manager advised there have been no notification of significant events made to the Ministry of Health, HealthCERT or other agencies since the previous audit. However on the day of the audit a Section 31 notice was sent to HealthCERT regarding one hospital level care resident who had recently been re-assessed for psycho-geriatric level care. The resident is being monitored by the mental health services for older persons until a bed is available at a facility in this geographical region. The family are well informed of the transfer process and reason for the transfer.</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</p>	<p>FA</p>	<p>Human resource management policies, procedures and processes are based on good employment practice and relevant legislation. The recruitment process is the responsibility of the manager and includes referee checks, police vetting for all new staff and health professionals qualifications are validated, as are annual practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed</p>

<p>the requirements of legislation.</p>		<p>orientation.</p> <p>Ongoing education is provided and planned on a yearly and two yearly basis including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. The service employs thirty nine (39) caregivers. Four caregivers are level 2 and 21 have completed all training requirements. The remaining care staff are enrolled and undertaking level four training currently. Five care staff from overseas have not completed any training. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 delivery, 24 hours a day, seven days a week (24/7). The design of the hospital is always considered by the manager when staffing the facility. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place with staff reporting that excellent access to advice is available when needed. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Senior care staff hold other responsibilities such as health and safety and administrative roles. Residents, staff and the general practitioners supported this. Observation and review of a four week roster cycle confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week registered nurse cover.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident information is collected and stored in accordance with the New Zealand Health Records Standard. A resident file is created on admission and essential information is entered on the day of admission. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>The current residents' records are filed in the nurses' station which is locked when not in use or unattended. Archived records of past and deceased residents are stored in a secure place.</p> <p>The residents' records sampled demonstrated that entries were legible, and the writer of each entry signed their name, initials and designation. A signatures register is maintained for all current staff and was updated as required.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The facility manager, clinical nurse manager and the qualified nurses are responsible for the admission process. In interviews conducted, the qualified nursing team reported that residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and GPs where required.</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 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>	<p>FA</p>	<p>Exit, discharge or transfer is managed by the qualified nurses, with an escort provided if required. The service uses the district health board (DHB)'s 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals were documented in the progress notes. An observation was made on the days of the audit of a resident being transferred to acute services. Transfer records were prepared in a timely manner and handover was given to the paramedics. Family of the resident reported being kept well informed during the transfer of their relative.</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 team is made and a new placement found, in consultation with the resident and whānau/family. Referral documents were sighted in the reviewed files. There is a clause in the access agreement related to when a resident's placement can be terminated.</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>Maygrove Village Hospital had a current medication management policy that identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Medication was stored safely and securely in locked medication trolleys in a locked medication room. A safe system for medicine management using an electronic system was observed on the days of audit. Interviewed qualified nurses demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. The RN was observed administering lunchtime medications. The medication trolley was kept within reach and the trolley locked; no medication was left on top of the trolley. Appropriate documentation was completed for medicines administered. All</p>

		<p>staff who administer medicines are competent to perform the function they manage. Current medication administration competencies were sighted for all staff who administer medicines. Annual medication management education was completed for all staff.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Interviewed staff reported that the registered nurses (RNs) complete medication reconciliation against the prescription when the medicines are received from the pharmacy. Electronic records of medication reconciliation were sighted. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly medication reviews by the GPs were completed and consistently recorded on the electronic medicine charts reviewed. Standing orders are used, were current and complied with guidelines. Records of annual reviews of the standing orders by all the five GPs were sighted.</p> <p>There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. Appropriate assessments were completed, and regular reviews of competency were completed. The medication was stored securely in locked drawers in the resident's room.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	<p>FA</p>	<p>The food service is provided on site by the village kitchen and is in line with recognised nutritional guidelines for older people. There are three qualified chefs with recognised food safety qualifications. Kitchen assistants have completed relevant food handling training. The menu follows an eight weekly cycle and summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries (MPI). A food verification audit was completed by the Auckland Council on 26 August 2019. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, were</p>

		<p>monitored appropriately and recorded as required.</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. Current copies of the dietary profiles were sighted in the kitchen records sighted. Special equipment, to meet resident's nutritional needs, was available.</p> <p>The kitchen and pantry were clean on the days of the audit. There was no expired food in the pantry. All the decanted food and cooked food in the fridge were covered and labelled. The kitchen manager reported that no food is reheated. Fridge and freezer temperatures were recorded.</p> <p>Interviewed residents reported satisfaction with the meal service. The kitchen manager reported that feedback on the food services is sought from residents and family through satisfaction surveys and residents' meeting. This was verified in the meeting minutes reviewed. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical manager reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The consumer and where applicable their family/whānau of choice are informed of the reason for decline and they are advised of other options or alternatives.</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>Validated nursing assessment tools, such as a pain scale, falls risk, pressure risk, nutritional, screening, continence, interRAI and cultural needs, were used to collect information and to identify any deficits and to inform care planning. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process. There was one resident who was assessed as needing psychogeriatric level of care. The resident was closely monitored by the mental health team and is awaiting placement for psychogeriatric care. Adequate staffing funded by mental health is in place to meet the resident's needs in the interim. The family was aware of the process and plan of care.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were individualised, 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. The reviewed care plans had detailed strategies to manage the identified needs to meet the desired outcomes.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Changes in care required were documented. Interviewed staff reported that the changes are verbally passed on to relevant staff at shift handovers. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The interviewed GPs verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Interviewed 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 residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two activities coordinators. The activities assessment is completed by the activities coordinators within two weeks of admission. This was evidenced in the residents' records reviewed.</p> <p>A social assessment and history were completed 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 residents' daily activities attendance was monitored and documented. Activities attendance records were sighted. Activities needs were evaluated regularly as part of the formal six-monthly care plan review. The activities coordinator reported that changes are made on the activities plan for any significant changes in activities participation.</p> <p>The planned activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. A weekly activities plan was posted on notice boards around the facility and activities for the day were written on the board and the activities coordinator reported that the board is updated daily. There is a wide range of activities planned to include puzzles, bingo, 'happy hour', pet therapy, church services, music, movies, 'sausage sizzles', birthday celebrations and manicures. Residents were observed participating in a variety of activities on the days of the audit.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents'</p>

		meetings and satisfaction surveys. Interviewed residents reported satisfaction with the activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The nursing staff document in the progress notes daily as confirmed in the reviewed residents' records. If any change is noted, it is reported to the RN. Long-term care plans evaluations occur every six months following six-monthly interRAI reassessments, or as residents' needs change, as was evident in reviewed files. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were being consistently reviewed and progress evaluated as clinically indicated. Short-term care plans were closed off as required. When necessary, and for unresolved problems, they were added to the long-term care plans. Interviewed residents and family confirmed being involved in evaluation of care six-monthly.
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. The interviewed GPs confirmed this. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team, eye specialists, podiatrist, physiotherapist and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. This was observed on the days of the audit when a resident was transferred to acute services for further management.
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	Staff follow documented processes for the management of waste, infectious and hazardous substances. Two maintenance staff were interviewed and had a good understanding of their responsibilities. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provided 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.

<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>CI</p>	<p>A current building warrant of fitness expiry date 16 June 2020 was publically displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with two maintenance personal and observation of the environment. One maintenance person interviewed is an electrical appliance service person (safety, competency and compliance) and has a New Zealand licence which was verified and expires 31 July 2020. The environment was hazard free, residents were safe and independence was promoted at all times.</p> <p>An identification of an opportunity for improvement resulting from incident reporting analysis was observed with increasing back strain being reported by staff from the previous year. A project was initiated and an action plan was developed and implemented by the manager with involvement of the assistant physiotherapist and the health and safety committee who fully supported the project. The benefits for staff and residents have been enormous and the project 'Reducing Back strain Incidents' was presented and well received at the WDHQ quality improvement workshop series this year 31 October 2019. The manager was presented with a certificate of achievement for the organisation and in recognition of the project and the outstanding outcomes achieved.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ensuite bathrooms in all residents' rooms. One bathroom with a bath is available if needed. Separate staff/visitors toilets are accessible. Additional large showers are available in each wing for residents needing hoist/transfers. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' 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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their individual rooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of all individual residents' rooms.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The main dining room and lounge areas are spacious and enable easy access for residents and staff. Smaller lounges are accessible in each wing. 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>Laundry is undertaken on site in a dedicated laundry by dedicated laundry staff. The care staff and laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Care staff are responsible for taking the dirty linen to the laundry mid-morning and laundry staff take over and ensure laundry is fully completed over the day. One laundry person is designated to this role Monday to Sunday. The cleaning service is also completed by one staff member Monday to Sunday. A supervisor is responsible for both areas of service delivery Monday to Friday and assists as necessary. All staff working in these two areas are fully trained. Training occurs annually as reviewed in the training records. Resident and family interviewed reported the laundry is managed well and that their clothes are returned in a timely manner. Chemicals are in appropriately labelled containers. The staff are awaiting new cupboards to be built for any excess cleaning/laundry products. The laundry is currently locked at all times when a staff member is not in attendance. Cleaning and laundry processes are monitored through the internal audit system and audits are completed regularly.</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>	FA	<p>Policies and procedures 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 current fire evacuation plan was approved by the New Zealand Fire Service on the 15 October 2004. The hospital was built after the Village and another letter is dated 17 August 2007. Fire training is held six monthly. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence event, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 50 residents. The available water meets the requirements of the Auckland City Council. Emergency lighting is tested regularly and recorded. There is no generator back-up on site but a generator can be hired if needed.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells and this was observed on the day of</p>

		<p>the audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security guard checks the premises at night.</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>	FA	<p>All residents' rooms and communal areas are heated appropriately. There is no air-conditioning in the building. Wall mounted fans have been installed in all service areas and in individual rooms as needed. Rooms have natural light and opening windows. The building is on the first floor of the village with lift access and a stairway. The residents and families confirmed the facility is maintained at a comfortable balanced 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>	FA	<p>Maygrove Village Hospital has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from an external specialist. The infection control programme and manual are reviewed annually.</p> <p>The infection control coordinator (ICC) has a job description with role and responsibilities defined. Infection control matters, including surveillance results, are reported monthly to the general manager, facility manager, clinical manager and tabled at the quality and risk committee meeting. This committee includes the general manager, facility manager, the health and safety representative, activities coordinator, household manager, administrator, administrator assistant, care coordinator and physiotherapy assistant and representatives from food services.</p> <p>A notification was posted at the reception that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>The ICC reported the availability of adequate human, physical and information resources to implement the infection control programme to meet the needs of the service and any outbreak of infection. The ICC coordinator has appropriate skills and knowledge for the role. She has attended relevant study days provided by the local district health board (DHB) as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GPs and public health unit, as required. The ICC has access to residents' records and diagnostic results to</p>

infection control programme and meet the needs of the organisation.		<p>ensure timely treatment and resolution of any infections.</p> <p>Emergency infection outbreak management equipment was in place and regular stock checks were completed to ensure safety for use when required.</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 and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed annually and included appropriate referencing.</p> <p>The nursing team, 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, cleaning wipes and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Interviewed staff verified knowledge of infection control policies, practices and where policies were located if required for referencing.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided annually by suitably qualified RNs and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was sighted in the reviewed records. Additional staff education has been provided when needed to address any identified needs, for example, external education was provided onsite by the wound care nurse specialist.</p> <p>The ICC and the clinical nurse manager reported that individual education was provided to residents when there were infection issues to be addressed. This was verified in the short-term care plans reviewed. The one-to-one education included reminders about handwashing and advice about remaining in their room if they were unwell.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, fungal, eye, chest, wound, bacterial and multi-resistant organisms. The ICC coordinator reviews all reported infections, and these are documented. Nursing staff reported that infections and any</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the infection control committee.</p> <p>Infection control internal audits were completed six-monthly to include staff hand hygiene, environmental hygiene, laundry services and kitchen hygiene. Corrective actions were discussed with staff and implemented. Documentation was sighted in the staff meeting minutes reviewed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. On the day of the audit there were 10 restraints in use and six enablers which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, records reviewed and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group is made up of the general practitioner, the clinical manager and the manager. The approval group is responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, resident's records and interviews with the manager that there were clear lines of accountability, that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>manager is the restraint coordinator and undertakes the initial assessment with input from the resident's family. The manager described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator/manager described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats and low beds). When restraints are in use frequent monitoring occurs to ensure the resident remains safe at all times. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraints is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved and if the policy was followed and documentation completed as needed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes an annual review of all restraint use which includes the requirements of the Standard. Monthly restraint meetings and reports completed and individual use is reported to the quality and staff meeting. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. A six monthly internal audit is carried out also which informs the meetings. Any changes to policies, guidelines, education and processes</p>

		are implemented if indicated. Data reviewed, minutes and interviews with the manager/restraint coordinator confirmed that restraint has been reduced from the previous year.
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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, 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 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	CI	<p>The manager and the physio-assistant were interviewed in regards to the physical environment, minimising harm, promoting safe mobility and aiding independence with the use of mobility aids appropriate for residents receiving care in this hospital care setting. Education was always provided to staff for transferring residents and use of hoists and other mobility aides to promote independence. However on reflection with the increasing incidence of staff reporting back sprain injuries it was observed to be a significant issue for health and safety of staff and the residents. A quality goal for the coming year was established as part of the</p>	<p>A continuous Improvement rating is made for the achievement beyond the expected full attainment for the project initiated after the increasing incidence of back strain was recognised. This was reported to have increased from 8 to 11 back strains in 2018 to 2019. The aim of the project was to reduce back strains by 25% by January 2020. Half of the reported back strains were associated with moving and handling residents incidents. The baseline data was collected, analysed and a graph was developed along with a cause and effect diagram with possible aetiology attributing to the back strain injuries. A process map for moving a resident at Maygrove Village Hospital was developed to identify the problem areas. Education was provided to staff in small groups with staff participating rather than the large group demonstrations previously. In addition a transfer plan was developed from each resident's care plan and a copy placed in each resident's wardrobe as a guide to staff. A post-education survey was completed to ascertain if staff thought the education provided was more informative or not and whether the transfer plan for each individual resident was read by staff and was helpful or not. Results from the survey were</p>

		<p>quality and risk improvement system to ensure this rate of injury for staff was reduced when meeting the needs of the residents. An action plan was developed and implemented.</p>	<p>published from staff discussions and feedback questionnaires. The outcome was that staff felt better informed and by using the transfer plans there was a reduction in back strain reported for this last year so far.</p>
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End of the report.