

# Gracedale Care Limited - Gracedale Hospital

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## 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:

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|---|--|----------------------------|
| <b>Legal entity:</b>  | Gracedale Care Limited   |                            |
| <b>Premises audited:</b>  | Gracedale Hospital   |                            |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |                            |
| <b>Dates of audit:</b>  | Start date: 11 February 2020   | End date: 12 February 2020 |
| <b>Proposed changes to current services (if any):</b>   | None   |                            |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 36   |                            |

# Executive summary of the audit

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## 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

Gracedale Hospital provides rest home and hospital level care for up to 36 residents. The service is operated by the Gracedale Care Limited and managed by a facility manager and a clinical coordinator. Since 2017 Howick Baptist Senior Living took over the management and the responsibilities of the facility in collaboration with Gracedale Trust Board. The Eden Alternative principles are being implemented across all areas of service delivery. Residents and families spoke positively about the care provided.

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

The audit has resulted in two continuous improvement ratings, one in safe and appropriate environment and one in service delivery. No areas were identified as requiring improvement.

## Consumer rights

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

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Staff have knowledge and understanding of the rights of residents and consumer rights legislation. Services are provided in a manner that respects residents' rights.

The individual values and beliefs of residents are documented and respected by staff. Staff communicated effectively with residents and their families and friends. Open disclosure is practiced. Residents have access to advocacy services and information on advocacy services is available to residents and relatives. Staff encourage residents to maintain links with their family/whanau and community.

There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. There were policies and procedures to guide staff in provision of support to residents who identify as Maori. There was no evidence of abuse, neglect or discrimination.

Gracedale Hospital has links 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

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| 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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Business and quality and risk management plans include the scope, direction, goals, values and a mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

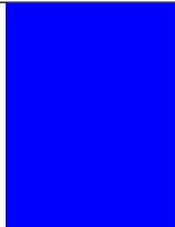
The Eden Alternative quality and risk management system implemented includes collection and analysis of quality improvement data, identifies any trends and leads to quality improvements. Staff are involved and feedback is sought from residents and

families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and 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 performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded electronically and password access is required.

## Continuum of service delivery

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

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and family. The care plans are developed by registered nurses with input from the residents, staff and family member representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents' assessed needs and abilities, and maintains their links with the community.

There was a safe medication management system in place and medication was administered by staff who are competent to do so. All medications were reviewed by the general practitioner (GP) according to policy.

The kitchen is managed by an independent catering service. Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

## Safe and appropriate environment

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



Standards applicable to this service fully attained.

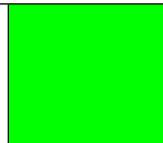
The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment and equipment requiring calibration is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are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

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

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

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs, should this be required. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, is implemented to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. No infection outbreaks have been reported 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 1                           | 44                  | 0  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 2                           | 91                  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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>Gracedale Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Residents were addressed by their preferred names and personal cares were provided in privacy, behind closed doors. The clinical coordinator (CC) and facility manager (FM) reported that 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 sighted.</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</p> | FA                | <p>General consent forms were signed for all residents on admission and the CC reported that these are discussed with residents and family on admission. Specific consent forms were signed for other procedures not included in the general consent form, as sighted in reviewed documents, for example, flu vaccination and catheterisation. Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements (EPOA) and processes for residents unable to consent is defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.</p> |

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| give informed consent.   |    |  |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>  |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Gracedale Hospital has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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. The facility supports the philosophy of The Eden Alternative, which is being implemented.</p>  |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>                                 | FA | <p>The complaints/compliments 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 were fully informed and knew how to do so. The facility manager has an open door policy if family/resident/staff wish to discuss any issues or concerns. A confidential box is also available at reception for any completed forms to be placed if needed.</p> <p>The complaints register is maintained by the facility manager. Seven minor complaints have been received since the previous audit with actions taken through to an agreed resolution. All complaints have been closed out effectively, dated and signed off by the facility manager. The required timeframes were met. Action plans reviewed showed any required follow-up and quality improvements have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>  | FA | <p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and through explanation and discussions with the FM, CC or admitting RN. The Code is displayed on notice boards throughout the facility, including the staff room together with information on advocacy services and</p>  |

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| their rights.  |    | how to make a complaint. Feedback forms were available and accessible at the reception area.  |
| <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>Interviewed 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 and the CC and the GP confirmed that private discussions are held in the resident's room or in the privacy of the boardroom.</p> <p>Residents are encouraged to maintain their independence by participating in the provision of own personal cares if desired and able, being involved in community activities, arranging their own visits outside the facility and participation in clubs of their choosing. Interviewed staff reported that assistance is provided as required. Reviewed care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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>Interviewed staff demonstrated understanding of 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. Residents are permitted to bring their own personal belongings from home including furniture if desired and a record of the personal property is maintained as was sighted in records reviewed.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>Interviewed staff demonstrated awareness of how to provide care to residents who identify as Maori in a manner that respects and acknowledge their individual and cultural, values and beliefs. On the days of the audit, there were no residents who identified as Maori, but there are policies and procedures for staff guidance and reference if needed. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. This was verified in the the electronic records sighted of a previous resident. There was a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice was available. Staff have received education on Maori health and cultural aspects.</p>   |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>  | FA | <p>Residents and family members verified that they were consulted as part of the admission process on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, specific cultural food preferences and spiritual beliefs. The resident satisfaction survey confirmed that individual needs are being met.</p>   |

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| which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  |    |   |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>              | FA | <p>Residents, family members and other visiting allied health professionals interviewed stated that residents were free from any type of discrimination, harassment or exploitation. Residents reported that they 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>  | FA | <p>Gracedale Hospital 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, mental health services for older persons, and education of staff. Staff attend internal monthly education sessions; good attendance was noted on the reviewed education attendance records. The general practitioner (GP) 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. Other examples of good practice observed during the audit included records of monthly staff meetings where different topics concerning residents are discussed along with other organisation wide topics (eg, health and safety, hazards, infection control, incidents, complaints, compliments, medication errors, quality improvement, restraint and audit results).</p> <p>Monthly residents' meetings are held where residents are encouraged to give feedback on activities, nursing and caregiving issues, cleaning, food, maintenance, complaints, compliments and laundry audits. This was verified by interviewed residents and meeting minutes sighted.</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 and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Completed accident and incident forms were sighted with a record of communication with family members maintained.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Staff able to provide interpretation as and when needed and through the use of family</p>  |

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|   |    | members where appropriate.  |
| <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>Gracedale Hospital is owned by Gracedale Care Limited and is managed by a trust board (five trust board members). The business plan 2019 – 2020 was reviewed. In 2017 management of Howick Baptist Hospital Senior Living (HBHSL) took over the management responsibilities for Gracedale Hospital. The HBHSL annual business plan reviewed is developed in March-April annually and identifies the major features of the business environment, the opportunities, risks and priorities of the organisation for the forth coming year. Decisions on budget priorities and investment decisions are based on the business priorities outlined in the business plan. The purpose, values, scope, direction and objectives of the organisation were included in the plans reviewed.</p> <p>Both services work collaboratively together. The management staff from HBHSL provide management supervision for the facility manager, clinical support as needed and the occupational therapist oversees the activities programme. In addition to this the property and service manager provides oversight for all health and safety in the workplace, equipment, purchases and resources, maintenance and any improvements made to the service. An accountant also oversees responsibilities for accounts and provides internet technology (IT) and payroll support to the administrator. Support is provided to maintain and support staff for the electronic resident information system in place at Gracedale Hospital which is newly implemented. The facility manager provides reports to both trust boards (Gracedale Board two monthly) and the (HBHSL) monthly. The FM is a member of the HBHSL continuous quality improvement and risk management committee and reports all statistics monthly. Minutes of meetings and copies of reports were reviewed. The chief executive officer (CEO) and the property services manager provide human resources management support and an external adviser is available for any staff issues and negotiates with unions as needed.</p> <p>The service is managed by a facility manager (FM) who holds relevant qualifications and has worked at the facility for sixteen years in different roles and as FM since 2016. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager is a registered nurse with a current annual practising certificate and has a post graduate diploma in advanced nursing - 2018. The FM interviewed verified knowledge of the aged care sector, regulatory requirements and maintains currency through attending clinical and management study days and courses as verified in the personal record reviewed.</p> <p>The service holds contracts with ADHB for rest home and hospital level care. Thirty six (36) residents were receiving care under the contracts; 28 hospital level care residents and eight (8) rest home level care residents, at the time of audit.</p> |
| Standard 1.2.2: Service   | FA | When the FM is absent, the clinical coordinator carries out all the required clinical and management duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a  |

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| <p>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>senior registered nurse and/or the FM. Support is provided by clinical management at HBHSL when required. The staff reported the current arrangements work 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 reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. The quality and risk system (HBHSL) has incorporated and embedded the Eden Alternative and has achieved successfully the ten Eden Alternative principles and this is being implemented at Gracedale Hospital with resident centred care. Gracedale Hospital staff are fully committed but are not ready as yet for formal registration. The FM and the clinical coordinator are Eden Associates as are other members of the staff. Group training is due in June 2020. The Gracedale Hospital Board are also fully committed to the Eden Alternative. The Eden Alternative principles as introduced, will drive all quality initiatives for all areas of service provision. The plan is shared with both sites. This included the management of incidents/accidents/near misses, complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infection surveillance and restraint minimisation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, quality and risk meetings and at staff meetings. Staff reported that the service philosophy supports staff involvement in quality and risk activities through audit activities. The administrator is the health and safety coordinator ensuring a safe environment for residents, staff and visitors to the facility. Employees are well informed of the health and safety policies and procedures and their obligations under the Health and Safety at Work Act 2015. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually, the most recent being July 2019. The overall result was very positive reflecting the dedication of the staff and management at Gracedale Hospital. Of most value was the feeling of security, the nurse call response system was seen as effective, residents were satisfied with the facility, the standard of maintenance and the care received by staff. Other suggestions related to the food service, community involvement in particular to increase opportunities for children and animals to visit Gracedale Hospital. Action plans were put in place and planning has occurred as verified in the activities plan for 2020 and a wider availability of food choices have been considered and changed into the rotating menu planning.</p> <p>Policies and procedures reviewed covered all necessary aspects of service delivery and met contractual</p> |

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|   |    | <p>requirements, including reference to interRAI Long Term Care Facility (LTCF) assessment tool and process. HBHSL are reviewing and renewing all policies and procedures to a different system and this is currently in transition. Policies are based on best practice and the Eden Alternative. 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 FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies as needed. The hazard identification register is maintained and has been reviewed regularly.</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>Staff document adverse and near miss events on an incident/accident/near miss form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the FM who reports this to the HBHSL continuous quality improvement (CQI) and risk management meeting. Minutes of meetings were reviewed. Feedback is provided to staff at the staff meetings held monthly.</p> <p>The FM described essential notification reporting requirements, including pressure injuries, skin tears, wounds and witnessed and unwitnessed falls. Since the previous audit there have been three Section 31 Notices to HealthCERT in relation to RN shortages at the time, a pressure injury and a resident absconded (went missing) but was later found. The FM maintains a Section 31 register which was reviewed.</p>  |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>   | FA | <p>Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and 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.</p> <p>Staff orientation includes all necessary components relevant to the role, both clinical and non-clinical. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance appraisal after three months and annually thereafter. Support is provided to the FM by the CEO of HBHSL, the property services manager and an external human resource advisor (HRA) who advises on any staff issues and communicates with unions for staff involved.</p> <p>Continuing education is planned two yearly and includes mandatory training requirements. Records reviewed (2018 and 2019) demonstrated completion of the required training. 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 ADHB. Currently there are eleven (11) level three and three (3)</p> |

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|  |    | caregivers who are level 4 trained on the qualification framework. Competencies are completed by the care staff and registered nurses and records are maintained by the facility manager/administrator. There were sufficient trained and competent registered nurses (5) maintaining their annual competency requirements to undertake interRAI assessments. The FM has completed the management interRAI training.   |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>      | FA | <p>There is a documented and implemented process for determine staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The design of the facility is taken into consideration. An afterhours on call roster is in place shared between the FM and the clinical coordinator. Staff reported at interview that good access to advice is available when needed. There is RN cover 24 hours a day. There are now adequate registered nurses to cover the roster reviewed. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations 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 first aid certificate. Team work is encouraged and promoted at all times. Staff rotate throughout the service so that they get to know all residents. Casual staff are available if needed. Any bureau staff are informed verbally by the senior nurse or clinical coordinator and provided with a handover sheet that provides a quick reference to residents without breaching residents' privacy and confidential information.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files reviewed. Day to day residents' cares were completed in the electronic information management system by all disciplines including the nursing team, Gp, activities and physiotherapist. Electronic records reviewed were current and accurate. This included interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and were readily retrievable using a cataloguing system. No personal or private resident information was on public display during the audit. Staff access the electronic residents' information through use of individual passwords.</p>   |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>   | FA | <p>Entry into Gracedale Hospital is facilitated and managed by the facility manager (FM), administrator, clinical coordinator (CC) and RNs. Enquiry forms are completed prior to admission and a follow up of the enquiry is completed by the administrator or FM to assess the outcome. Records of enquiry outcomes were sighted on the completed enquiry forms. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service, the admission process and</p>   |

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| <p>timely, and respectful manner, when their need for services has been identified.</p>  |           | <p>given a tour of the facility if desired. 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.</p> <p>The RNs are responsible for completing the admission assessments and documentation. Signed admission agreements were sighted in reviewed records and charges and additional costs were indicated. Service charges comply with contractual requirements. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details and assessments.</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>The CC and RN reported that the exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident, through the transfer documents completed and phone handover to the receiving provider. Referrals are documented in the progress notes as sighted in the electronic records. The CC reported that 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 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 1.3.12: 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>There is a documented policy on the management of the medication system. The medicines management system complies with legislation, protocols and guidelines. The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. All medication entries sampled on the electronic system complied with legislation, protocols and guidelines. The e-prescribing electronic system is accessed by use of individual passwords. Allergies were documented, current identification photos were uploaded and three-monthly reviews were completed. The RN was observed administering medication correctly. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service.</p> <p>The service uses pharmacy pre-packed packs that are checked by the RNs on delivery. The controlled drug register was current and correct. Weekly and six-monthly stock checks were conducted and all medications were stored appropriately. All medications sighted were within current use by dates. There was one resident self-administering medication at the time of the audit and this person was assessed as competent to do so. There is a policy and procedure for self-administration of medication to guide staff if required.</p> <p>Annual medication administration competency was completed for all staff administering medications and</p> |

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|   |           | <p>medication training records were sighted.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly medication reviews were consistently recorded on the medicine charts.</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 meal service is prepared on site by an external contractor and served in the respective dining areas. The menu was reviewed by a dietitian in November 2019. The kitchen manager, who is the chef has completed a safe food handling qualification. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan and the kitchen manager confirmed awareness on dietary needs of the residents. Copies of residents' dietary requirements were sighted in the kitchen file. The residents had a dietary profile developed on admission which identifies dietary requirements, likes and dislikes. The residents' weight is monitored regularly and supplements are provided to residents with identified weight loss issues. The caregivers assist with serving the prepared meals and they have received training in safe food handling.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Left-over food was labelled, covered and use by dates were recorded. Electronic records of temperature monitoring of fridges and freezers are maintained. Regular cleaning was undertaken with completed electronic cleaning schedules sighted. The residents and family interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines. The service operates with a current approved food control plan and registration issued by the Ministry of Primary Industries. Food temperatures, including for high risk items, were monitored appropriately and recorded as part of the plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p>   | <p>FA</p> | <p>The CC reported that the reasons for a declined entry might be because the prospective resident does not meet the entry criteria, for example, higher level of care required, services not provided by the facility or there is currently no vacancy. The prospective resident and family are advised of other alternative service providers</p>  |

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| <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>and the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The reason for the decline to entry is provided to the prospective resident and/family; this was verified on the enquiry forms reviewed.</p>  |
| <p>Standard 1.3.4: Assessment<br/>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>                               | <p>FA</p> | <p>Nursing assessment tools such as a pain scale, continence, pressure injury risk, mobility and manual handling risk are completed on admission as a means to identify residents' needs and goals to inform care planning. All assessments reviewed were completed in a timely manner. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the five trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>  |
| <p>Standard 1.3.5: Planning<br/>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>                       | <p>FA</p> | <p>Long term and short-term care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in long term care plans reviewed.</p> <p>Care plans evidence service integration with documentation by the nursing staff in progress notes, activities notes, medical and allied health professionals' notations included in the care plans as required. Any change in care required was documented and verbally passed on to relevant staff as confirmed by interviewed staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>   |
| <p>Standard 1.3.6: Service Delivery/Interventions<br/>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>CI</p> | <p>Documentation, observations and interviews verified that care provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed on every shift by the RN electronically with input from the caregivers. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs. Staff confirmed they have access to the supplies and products they needed. Interviewed staff reported that there were adequate resources to provide quality care for the residents. The caregivers confirmed that care was provided as outlined in the documentation. Interviewed family members and residents reported satisfaction with the services provided.</p> |

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| <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>A social assessment and history is completed on admission to ascertain residents' needs, interests, abilities and social requirements. The activities programme is provided by the activities coordinator. The activities coordinator completes the activities assessment within one week of admission. The activities programme is planned with input from residents monthly through the residents' committee. The activities planner is posted on the notice boards in each dining room and individual resident's room. The daily activities are written on a white board at the entrance to the activities room.</p> <p>There is a variety of planned activities including birthday celebrations where the residents bake the cake each month, monthly theme celebrations, outside entertainers are invited, gardening, Tai chi, exercises, church services, newspaper reading, walks, movies, knitting, bus outings, housework, outdoor sports and games. Residents were observed participating in a variety of activities on the days of the audit.</p> <p>Activities reflected residents' goals and ordinary patterns of life. Individual and group activities are offered, and they are combined for rest home and hospital level residents. Residents and families/whānau are involved in evaluating and improving the programme through monthly activities meeting to plan the programme, residents' meetings and satisfaction surveys. Feedback received from residents was used to change and improve the activities programme, documentation was sighted.</p> <p>Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated as part of the formal six-monthly care plan review. Interviewed residents confirmed they find the programme satisfactory.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months following six-monthly interRAI reassessment, or as residents' needs change. The degree of achievement of desired goals was documented. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short term care plans being consistently implemented, reviewed and progress evaluated as clinically indicated were noted for chest infections, wounds and eye infections. When necessary, and for unresolved problems, conditions were added to long term care plans. Residents and families interviewed confirmed their involvement in evaluation of progress and any resulting changes.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for</p>   | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although Gracedale Hospital has a contracted GP and physiotherapist, residents have an option to choose other allied health professionals if desired. This was confirmed by an external professional interviewed on the days of the audit. 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 speech</p>  |

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| <p>access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>   |           | <p>language therapists, ophthalmology and the hospice service. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>  |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Personal protective equipment (PPE) and resources are readily available and additional replacement stocks and for use in an emergency situation was sighted.</p>  |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>   | <p>FA</p> | <p>A current building warrant of fitness expires 30 March 2020 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed, an interview with the property and service manager and observation of the environment. The next electrical and calibration checks are due April 2020. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and a development programme implemented has gained the facility a continuous improvement rating for the total enhancement of the external setting which is now enjoyed by a majority of the residents. Residents and staff confirmed at interview that they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. A maintenance staff member employed is responsible across both the HBH Senior Living and at Gracedale Hospital sites for the maintenance programme. The facility was well maintained on observation, both externally and internally.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>  | <p>FA</p> | <p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. This includes a household model of design with thirty four (34) premium rooms all with ensuites and two (2) standard rooms with shared bathrooms. Each household (wing) has eight bedrooms with their own bathrooms and a shared</p>  |

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| <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>lounge/dining area. The bathrooms are well designed with appropriately secured and approved handrails being provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. All staff have completed manual training provided by the contracted physiotherapist.</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 bedrooms safely. All bedrooms provide single accommodation. Rooms are individualised with residents' own personal items and furnishings, photographs, framed art work and ornaments. Rooms are adequate for staff to use a hoist or other forms of equipment safely when and if needed. There are areas to store mobility aids when not in use. Staff and residents reported the rooms were adequate in size and the design concept of the household works effectively and provides a homely environment in line with the Eden Alternative philosophy.</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> | <p>FA</p> | <p>In addition to the household concept of having a lounge/dining area in each household for the residents, communal areas are also available for residents to engage in activities. The main lounge area is very spacious and comfortable and enables easy access for residents and staff. Residents can access areas for privacy if needed. Furniture is appropriate to the setting and resident's 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</p>  | <p>FA</p> | <p>Laundry is undertaken on site in a dedicated laundry. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Personal protective equipment and resources are available and relevant education was provided on the 02 February 2020. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The property and service manager explained the laundry processes and the purchasing of the resources and equipment for the laundry. A contracted service provider checks the machinery regularly in the laundry and replaces the chemicals as needed. Since the previous audit a new access and window (ranch slider) has been added to the laundry and new commercial equipment/appliances has been purchased to replace the previous equipment available.</p> |

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| is being provided.   |    | The laundry/cleaning staff stated that the service runs efficiently and staffing meets the needs for both the cleaning and laundry services. The home was very clean and tidy on visual inspection during the audit. All staff have completed chemical safety training 20 January 2020 and certificates of this were sighted.  |
| <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, procedures and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides and directs the facility in their preparation for any disasters and describes 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 19 April 2004. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being 03 December 2019 with thirty (30) staff in attendance. The fire security service providers run the training days in June and December. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and that training was provided 25 November 2019.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, continence products, blankets, pagers and gas BBQ's were sighted and meet the requirements for the thirty six (36) residents. Water storage was sighted and emergency lighting is available and is tested regularly by the contracted fire security service.</p> <p>Staff carry pagers and this alerts them to residents requiring assistance. Audits are completed on a regular basis and residents and families reported staff respond promptly to residents requiring assistance.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at pre-determined times and the main gate is locked at 9pm. Staff have swipe card access to the gate and the front door. A red light on the board in the nurses' station alerts staff if a door is open after hours.</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 | All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided with underfloor heating in resident's rooms and communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.   |
| Standard 3.1: Infection  | FA | Gracedale Hospital has implemented an infection prevention and control (IPC) programme to minimise the   |

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| <p>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>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 infection prevention and control experts. The infection control programme and policies are reviewed annually.</p> <p>The infection control coordinator is a registered nurse whose role and responsibilities were defined the job description sighted. Infection control matters, including surveillance results, were reported monthly to the clinical coordinator and facility manager, and tabled at the monthly infection control committee meeting. This committee includes the infection control coordinator (ICC), facility manager, clinical coordinator, a caregiver, laundry and household representative and the health and safety coordinator.</p> <p>There was signage at the main entrance to the facility that requests anyone who is, or has been unwell with flu like symptoms or a contagious illness not to enter the facility. Interviewed staff were aware of their infection prevention and control responsibilities in regards to staying away from work if unwell as guided by the policies and procedures.</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>  | FA | <p>The ICC has appropriate skills, knowledge and qualifications for the role, and has been in this role for a year. The ICC has completed relevant training in infection control with an external provider and has attended relevant study days through the local DHB, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>Adequate resources to support the programme and any outbreak of an infection were observed on the days of the audit. Interviewed staff confirmed this.</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</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 last reviewed in November 2019 and included appropriate referencing.</p> <p>The caregivers, RNs, cleaning, laundry and kitchen staff, were observed following appropriate procedures, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>  |

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| <p>organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>   |           |  |
| <p>Standard 3.4: Education<br/>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>   | <p>FA</p> | <p>Infection control education is provided by the ICC for all staff annually. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. A record of attendance was maintained - record sighted. When an infection outbreak was notified, there was evidence that additional staff education has been provided in response to infection outbreaks.</p> <p>Education with residents was generally on a one-to-one basis when they have acute infections and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>  |
| <p>Standard 3.5: Surveillance<br/>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, influenza, skin, and lower respiratory tract. The ICC reviews all reported infections and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs and this was confirmed by interviewed caregivers.</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 month and this is reported to the clinical coordinator, infection control committee and staff. Infection control audits were completed by the ICC as part of ongoing monitoring and evaluation of infection control procedures in place. Corrective actions were implemented to address the identified gaps as sighted in records.</p> |
| <p>Standard 2.1.1: Restraint minimisation<br/>Services demonstrate that the use of restraint is actively minimised.</p>  | <p>FA</p> | <p>The service philosophy states a commitment to promoting a restraint free environment and to providing the staff with good guidelines to enable them to prevent the need for restraint. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a good understanding of the organisation's policies, procedures and practice and the role and responsibilities. On the day of the audit no residents were using a restraint and no restraint has been used for the last two years as per the restraint register reviewed. No</p>   |

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|  |  | residents were using enablers. Enablers, when used, are the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints when in use. |
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## Specific results for criterion where corrective actions are required

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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.

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## 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.

| Criterion with desired outcome   | Attainment Rating | Audit Evidence   | Audit Finding   |
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| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed</p> | CI                | <p>A project was implemented to reduce the rate of falls and falls related injuries in year 2019. The previous falls prevention plan included assessment and identification, individualised falls prevention, physiotherapy review, review of polypharmacy, vitamin D and calcium supplement. There was a total of 103 falls in 2018.</p> <p>The new falls prevention plan implemented in 2019 included:</p> <p>Implementation of LED lights in the corridors and residents' room to</p> | <p>Evaluation of the implemented interventions was completed. Positive feedback was received from residents and families on improved lighting. Staff have gained increased awareness on falls data and ways to prevent and minimise falls. Planned maintenance is to upgrade all lights to LED. A significant reduction in falls of 24.3% was noted for 2019; 78 falls were reported in 2019 as compared to 103 reported in 2018.</p> <p>Involvement of non-clinical staff, families and residents resulted in increased awareness of interventions and therefore prompt and appropriate responses for the residents' safety.</p> <p>There has been an increase in Vitamin D uptake for residents. A reduction in injuries sustained following a fall was noted as an outcome of the project. Out of 78 falls reported in 2019, for 22 incidents there was no injury, and other incidents resulted in bruises, abrasions and minor skin tears. Two falls resulted in fractures that did not require surgical intervention; they healed with physiotherapy and rehabilitation.</p> |

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| <p>needs, and desired outcomes.</p> |  | <p>improve visibility.</p> <p>Residents' rooms were repainted in a light colour and residents' furniture was rearranged to make it more spacious to improve the environment.</p> <p>A new falls report form that captures more specific data relevant to the event was implemented and a post fall assessment incorporated onto the report; interventions were based on the assessment form.</p> <p>The GP was involved in the post fall assessment process and residents with high risk of falls were reviewed and vitamin D was prescribed.</p> <p>A system to increase staff awareness on high falls risk residents was introduced through a falling star sign on the resident's door for staff to easily identify the residents at risk. This also enabled non clinical staff to identify the falls risk residents and they are able to assist or remind the residents to use mobility aids if required. Residents who are 'frequent fallers' are also discussed in monthly RN forums and interventions in place evaluated for effectiveness.</p> <p>Falls prevention training was provided for all staff and ongoing discussions held with the non-clinical staff, including volunteers and family members.</p> <p>The activities coordinator was trained by the physiotherapist on some</p> |  |
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|   |    | <p>muscle strengthening exercises to incorporate in daily activity sessions.</p> <p>Equipment to maintain residents' independence with mobility was provided with input from the physiotherapist, for example, low low beds, sensor mats, mattress on the floor to reduce harm from fall, bed levers, monkey bars and increased frequency of visual checks.</p> <p>A visual representation of falls data is displayed in the staff room notice board and staff understood how to interpret the falls graphs.</p> <p>Interviewed staff were demonstrated awareness of the above interventions.</p>                           |   |
| <p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p> | CI | <p>While there were well maintained garden and lawn areas provided at the facility, there was a recognised need to ensure the external areas were safe and accessible to meet the needs of the residents. The previous outdoor setting was established in 2004 when the service opened the new facility and it was timely to undertake and be able to maximise the use of the external garden area for the residents to enjoy and for activities to be provided outside of the facility. A project was instigated by the activities staff and management to improve the external setting for the residents to enjoy the</p> | <p>A continuous improvement rating is made for achievement beyond the expected full attainment as a result of an opportunity developed to fully utilise existing outdoor areas for residents to enjoy by themselves or with their family or to have activities provided in an outdoor setting. An external area which was located in the main garden area outside the facility was rarely used by residents and a gazebo/shade house was not welcoming by design or the materials used as this attracted insects and seating was inappropriate for the elderly. A project was instigated with resident, family and staff involved and a plan was made. A contractor was employed to complete a paved area to make it safe for all residents including wheelchair access. The maintenance staff with the involvement of one resident built a raised garden bed and the area was enhanced with more outdoor furniture, such as a bench, umbrella, and this assisted in getting more residents involved in the gardening activities. The gazebo was totally renovated and is now available for residents and families to use it safely and appropriate seating and a table has been provided. Gardeners receive feedback from residents and involve them before making any changes to the garden outside the individual resident's rooms. This project when completed has been evaluated on several occasions and reflected positive feedback from residents and</p> |

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|  |  | outside especially for the summer months and also in the winter with the Gazebo being more user friendly and more comfortable for residents to access. | family and increased satisfaction about the enjoyment of pursuing activities outside the facility. In addition to this, there has been increased resident satisfaction around ground maintenance and plants grown around the facility. |
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End of the report.