

Rangiura Trust Board - Rangiura Rest Home & Retirement 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:	Rangiura Trust Board
Premises audited:	Rangiura Rest Home & Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 September 2020 End date: 17 September 2020
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:	73

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Rangiura Rest Home and Retirement Village (Rangiura Home) provides rest home, dementia and hospital level care for up to 76 residents.

The service is owned and operated by the Rangiura Trust Board and managed by a general manager and a clinical nurse leader, plus other people in management roles, for example, human resources, finances, food services, and housekeeping.

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 files, observations and interviews with residents, family members, management, staff, and a general practitioner (GP).

The GP, residents and families spoke positively about the care provided.

This audit has resulted in five new areas requiring improvement and one ongoing corrective action. These relate to weekend cleaning hours, residents who self-administer their medicines, the fire evacuation scheme, stored water for emergencies, records of restraint monitoring and review of the infection control programme. Achievements in the staff education programme is rated as continuous 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 interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. 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.

Residents who identify as Māori have their needs met in a manner that respects their 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, and complaints were being 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was 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 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 is used to identify and deliver ongoing training. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

Medicines are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. There is secure storage for chemicals and equipment. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Residents reported a timely staff response to call bells. Security is maintained. Communal and individual spaces are maintained at a comfortable temperature.

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.		Some standards applicable to this service partially attained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Seven enablers and eight 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 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.		Some standards applicable to this service partially attained and of low risk.
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The infection prevention and control programme, led by a trained infection control coordinator, aims to prevent and manage infection. 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.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	2	3	0	0
Criteria	1	94	0	3	3	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>Rangiura Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in 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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent forms. Residents who were unable to provide consent, for example, those who are living with dementia, had the enduring power attorney (EPOA) involved in the consent processes. The GP, residents and family/EPOA were involved in the advance care planning and resuscitation treatment planning. Where residents were unable to consent for a resuscitation treatment plan, the GP was responsible for making a medical decision. 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>Interviewed residents and family reported that a copy of the Code, which also includes information on the Advocacy Service was given on admission. 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. Residents have an independent advocate who runs their 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. The facility supports the philosophy of 'The Eden Alternative'.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends in normal circumstances. However, due to the COVID-19 pandemic infection control requirements, visiting was restricted to one chosen family member/representatives daily for 30 minutes per visit and video calling was encouraged using facility owned iPad. Residents were observed communicating with family via the video calling on the days of the audit. 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 what to do if they had concerns.</p> <p>The complaints register reviewed showed that 18 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The human resources manager is responsible for complaints management and follow up. 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 their rights.</p>	<p>FA</p>	<p>Residents and family 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 discussion with staff on admission. The Code is displayed in several places around the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents' individual choices were documented in the documents reviewed.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room and personal cares were provided behind closed doors.</p> <p>Residents were encouraged to maintain their independence by participation in community activities and in providing their own personal care if able to. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented 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 as sighted in training records. Interviewed family and residents reported that no abuse or neglect has been witnessed.</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>There were residents who identified as Maori on the days of the audit. The residents were supported to integrate their cultural values and beliefs in their day to day activities. The principles of the Treaty of Waitangi were incorporated into day to day practice, as was the importance of whānau. There was a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice was available and was supported by staff who identify as Māori in the facility. The interviewed Māori residents and their whānau reported that staff acknowledged and respected their individual cultural needs.</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' representatives/enduring power of attorney (EPOA) were consulted for the residents in the dementia unit. Residents' personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Interviewed residents and family members stated that residents were free from any type of</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>discrimination, harassment or exploitation and felt safe. Interviewed staff reported that the induction process for staff included 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 and monthly education on professional boundaries was conducted. Staff demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. There were policies and procedures that serve as a guide for staff.</p>
<p>Standard 1.1.8: Good Practice 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 team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. 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 to access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included incident reporting systems that were linked to open disclosure and quality improvement.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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 evident in residents' records reviewed. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Interpreter services information was included in the admission agreement.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The general manager (GM) has been in the post for 24 months. This person has business management qualifications. Responsibilities and accountabilities are defined in this person's job description and individual employment agreement. The board are kept informed verbally and in writing by the GM of all operational, quality and risk matters, confirmed by review of a sample of board meeting minutes and reports for 2020.</p> <p>Rangiura Trust Board has agreements with the DHB for age related care (ARC) in rest home,</p>

		<p>dementia, and hospital (medical, geriatric care and palliative care) respite/short stay and day services.</p> <p>On the day of audit 73 of the 76 beds were occupied. Thirty-three residents were receiving rest home level care and 25 residents were receiving hospital level care. There were 15 of the 16 beds occupied by residents in the secure unit. There was one resident under the age of 65 years under the ARC contract, whose care was reviewed in depth.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The human resources (HR) manager is nominated as the general manager (GM) with support from the clinical nurse leader (CNL) when the GM is absent.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of complaints, internal audits across all areas of service delivery and monitoring of outcomes, resident and relative satisfaction surveys and the reporting and collation of adverse events, such as accidents/incidents, pressure injuries, restraint interventions and infections.</p> <p>The organisation uses a sector standardised system for reporting their quality data, for example, number of falls with or without injury, medicine errors, pressure injuries, restraint, urinary tract infections, bruising and skin tears, and staff incidents. This data is collated by the nominated health and safety officer who conducts a monthly analysis looking for trends and ensuring that actions are underway to remedy any unwanted trends. Where gaps or deficits in service delivery are identified, corrective actions are developed and implemented to address any shortfalls. All quality data is benchmarked across other similar facilities in NZ and against eight other age care facilities in the region who belong to the same group.</p> <p>Information from quality monitoring is shared with staff at their meetings and written information was observed to be on display in staff areas. The staff interviewed confirmed that they are kept informed about the quality and risk management processes through internal audit activities and acting as representatives for health and safety matters.</p> <p>Resident and family satisfaction surveys are completed annually. Results from these and interviews</p>

		<p>revealed no major issues or areas of concern.</p> <p>Policies and procedures are controlled and managed by the quality system operator to ensure a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies are based on best practice and cover all aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process.</p> <p>The health and safety officer who is also the human resources (HR) manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Hazard identification processes are implemented, and the organisation's risk/hazard plan is updated at regular intervals. There had been no staff injuries requiring notification to Worksafe NZ. The health and safety team comprises health care representatives, the CNL, training coordinator, diversional therapist (DT) and leaders from hospitality and maintenance. The team meet regularly. Minutes of these revealed that upward or downward trends in service delivery were discussed and ideas for improvement or to mitigate recurrence, were formulated for implementation. This group also serves as the quality and risk monitoring team.</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>All adverse and near miss events are entered into an electronic system which immediately alerts the GM, clinical nurse leader and the chairperson of the trust if the level of risk is critical or major. The system collates events, into type, resident and the most common time and place which allows quick analysis for trending.</p> <p>A sample of incidents forms reviewed contained sufficient description of the event, who had been notified, and that each incident had been reviewed and/or investigated if follow up was indicated.</p> <p>Adverse event data is collated and presented to the health and safety/quality committee and the health and safety reports go to the board and staff. Incident data is being benchmarked across a group of other age care provider that the organisation belongs to - Community Trusts in Care Association NZ (CTCA), and nationally with other like age care facilities.</p> <p>The GM and HR manager are responsible for essential notification reporting. Both understand the requirements. There have been four notifications of significant events made to the Ministry of Health, since the previous audit. Two were notifying changes in Trustees, one was a police investigation about theft from a resident, and one about an intruder.</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>	<p>FA</p>	<p>Staff management policies and processes 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 ten 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 and the new staff member is 'buddied' for three consecutive shifts and competency assessed before working on their own. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review. Annual performance appraisals have been completed. Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated completion of the required training.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated that 30 of the 54 health care assistants (HCAs) have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). Ten have achieved level 3, and 6 have achieved level 2. A rating of continuous improvement is awarded in 1.2.7 in relation to staff training.</p> <p>Three RNs, the CNL and the physiotherapist are maintaining annual competency requirements to undertake interRAI assessments.</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>PA Moderate</p>	<p>There is a documented and implemented process for determining care staff levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are adjusted to meet the changing needs of residents. There are seven RNs employed, including the fulltime clinical nurse leader, a fulltime physiotherapist and 54 HCAs. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Observations, interviews with management and review of two months of the roster cycle confirmed that adequate care staff and RN cover has been provided, with staff replaced in any unplanned absence by bureau staff. A number of casual staff have been employed to cover absences and recruitment to build up the casual pool of healthcare assistants was ongoing.</p> <p>Residents and family members were satisfied with staff cover.</p> <p>All RNs are maintaining a current first aid certificate with cardio-pulmonary resuscitation (CPR) and there is 24 hour, seven days a week (24/7) RN coverage in the facility. Only staff who have</p>

		<p>completed educational achievements in dementia care (US 23920-23923) are rostered for duties in the secure unit.</p> <p>There are sufficient numbers of allied staff employed and on site for other work tasks, with the exception of cleaning staff on the weekends. Action is required to ensure an adequate number of cleaners are rostered on for weekends.</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 sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes 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 were held securely on site and were readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. Residents' files were kept in cupboards in the locked nurses' stations.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter Rangiora Rest Home 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, the admission process and pre-admission pack to be completed by resident/family prior admission. The clinical nurse leader (CNL) stated that updated information was sought from NASC and the resident's GP for residents accessing respite care. However, currently due to Coronavirus pandemic restrictions, respite care admissions have been put on hold.</p> <p>Interviewed family members reported satisfaction with the admission process and the information that had been made available to them on admission. The reviewed files contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Residents in the dementia unit had their admission agreements signed by the enduring power of attorney (EPOA). Service charges complied with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	FA	<p>Exit, discharge or transfer was managed in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses transfer forms to facilitate transfer of residents to and from</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>acute care services. Open communication between all services, the resident and the family/whanau were confirmed in records reviewed. At the time of transition between services, appropriate information was provided for the ongoing management of the resident. All referrals were documented in the progress notes. Interviewed family members reported being kept well informed during the transfer of their relative. 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>PA Moderate</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>The medicine management system observed on the days of the audit was paper based. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check the delivered medications against the prescription and records of this were maintained. The RNs are responsible for medication reconciliation when a resident is transferred back to the facility from acute services as reported by the CNL. All medications sighted were within current use by dates. Clinical pharmacist input was provided on request. 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>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 GP reviews were consistently recorded on the medicine chart. Standing orders were not used. Residents who were self-administering medications did not have their self-administration competencies reviewed three-monthly as required.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Medication errors were documented, analysis completed, and corrective actions were put in place.</p>
<p>Standard 1.3.13: Nutrition, Safe</p>	<p>FA</p>	<p>The food service is provided on site by qualified cooks and a kitchen team and was in line with</p>

<p>Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a five weekly cycle and has been reviewed by a qualified dietitian within the last two years. 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. The service operates with an approved and current food safety plan and registration issued by Ministry of Primary Industries (MPI). Food temperatures, including for high risk items, were monitored appropriately and recorded as part of the plan. The food services manager has completed a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>Nutritional assessments were completed for each resident on admission to the facility and a dietary profile developed. Residents' personal food preferences, any special diets and modified texture requirements were made known to kitchen staff and accommodated in the daily meal plan. Copies of dietary profiles were kept in the kitchen folder. Residents in the secure unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet residents' nutritional needs, was available.</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>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 CNL reported that if a referral for 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. Examples of this occurring were discussed.</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>Nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and continence assessment, were used to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents had 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.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with information from the nursing team, activities, medical and allied health professionals' assessments and recommendations. Any change in care required was documented and verbally passed on to relevant staff as verified in the reviewed records and in staff interviews. Behaviour management plans reviewed included triggers and appropriate interventions. All staff had access to care plans including short term care plans. 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 attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP and the nurse practitioner visit the facility four days per week: two days by the GP and two days by the nurse practitioner. The interviewed GP verified that medical input was sought in a timely manner, medical orders were followed, and care was provided as recommended. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were 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>Two trained diversional therapists (DTs) holding the national Certificate in Diversional Therapy and one assistant who has completed Careerforce level 4 training were responsible for the implementing the activities programme.</p> <p>The DTs reported that residents' social profiles are completed by the family prior to admission or completed by the DT with input from the resident and/family on admission to ascertain residents' needs, interests, abilities and social requirements. Activities care plans were completed by the DTs with information obtained from the social history assessment and observations from staff. Twenty-four-hour care plans were completed for all residents in the dementia unit. Activities assessments were regularly reviewed to help formulate an activities programme that is meaningful to the residents. Residents' activity needs were evaluated as needed where a significant change in a resident's participation was noted and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were offered. Activities on the programme included church services, board games, bowls, quiz, art, music and van outings. Daily attendance records were maintained and documentation in activities progress notes was completed. Residents</p>

		<p>and families/whānau were involved in evaluating and improving the programme through residents' meetings, multidisciplinary meetings with family and residents, and satisfaction surveys. Residents interviewed confirmed they find the programme satisfactory.</p> <p>Activities for residents from the secure dementia unit were specific to the needs and abilities of the people living there. Activities were offered at times when residents were most physically active and/or restless. This included small walks in the secure garden area and one on one activities like manicure, bowls and music therapy.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the healthcare assistants. They reported that any changes noted were reported to the RNs. The RNs document in the progress notes daily. This was verified in the documents reviewed.</p> <p>Formal care plan evaluations were completed and documented every six months following the six-monthly interRAI reassessments and when residents' needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans reviewed were evaluated consistently as clinically indicated. Examples of short-term care plans sighted were for urinary tract infections, wounds, and chest infections. Unresolved problems were added into long term care plans. Residents and families/whānau interviewed confirmed 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 access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The CNL reported that residents are supported to access or seek referral to other health and/or disability service providers. Where other non-urgent services were indicated or requested, referrals were sent by the GP or RN to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team, hospice and eye specialists. The resident and the family/whānau were 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 dictated. Adequate information was provided to ensure continuity of care for the resident. The CNL reported that a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family, when the needs of a resident changed and they were no longer suitable for the service.</p>
<p>Standard 1.4.1: Management Of</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted</p>

<p>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>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.</p> <p>There were plentiful supplies of protective clothing and equipment (masks, gloves, disposable aprons, footwear, eye protection) available on site and staff were observed to be using this. All visitors were being temperature checked and provided masks to wear on the days of audit. Visits were limited to 30 minutes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry 07 December 2020) is publicly displayed. There has been no change in the physical layout of any buildings since the previous audit.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Regular inspections are carried out to ensure the environment is hazard free, that residents are safe and independence is promoted. The furniture, fittings and chattels were observed to be in good condition. Medical equipment is checked and calibrated annually, and the lifting hoists are checked and maintained by an external supplier each year. Electrical items had been recently tested and tagged.</p> <p>Visual inspection showed that all external areas are appropriate to the resident groups and review of the maintenance records confirmed these are regularly maintained for safety.</p> <p>The environment in the dementia unit was safe and appropriate for the people residing there. There was no special equipment in use. Access to the kitchen was secured with a gate. Furniture and surroundings were suitable.</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>	FA	<p>There were adequate numbers of accessible bathroom and toilet facilities throughout the facility. This included shared ensuite rooms in one wing and staff/visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water is moderated by tempering valves and temperatures are tested monthly. The records of these revealed that temperatures are kept within a safe range.</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>Each bedroom provides enough space for residents and staff to move around safely. The bedrooms are for single accommodation, except for one room being shared by a couple. Rooms are individualised with furnishings, photos and other personal items displayed.</p> <p>There was sufficient room throughout the facility to store mobility aids, wheel chairs and mobility scooters. Staff and residents were satisfied with the bedrooms.</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>The main facility is spread across four different wings, each with a small lounge, with comfortable seats and books available for quiet time. Residents are served meals in three different dining areas, with some temporarily using the main hall as only two people were being seated at the same table for Covid19 precautions. There is one large dining room which has a smaller dining area set up adjacent to it and there is a separate dining room in the new wing. All are within easy walking distance from bedrooms. A choice of good-sized lounges are available for activities.</p> <p>The dementia unit provides a large open lounge, separated by a 'semi wall' with a designated dining area.</p> <p>During the current 'lock down' visitors were booking 30 minute visits. All were screened before entering the home and required to wear face masks.</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>	<p>FA</p>	<p>Laundry is washed and dried on site in a designated laundry by dedicated laundry staff who are employed seven days a week. The laundry staff interviewed demonstrated a good knowledge about safe and hygienic processes, using dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>A team of cleaners receive ongoing support and training from a household manager, and all have completed an NZQA Level 2 qualification in cleaning. This was confirmed in interview with cleaning staff and review of training records. When not in use, cleaning chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by the visiting chemical supplier.</p> <p>There is a requirement in standard 1.2.8 to review the number of cleaners rostered on each weekend.</p>
<p>Standard 1.4.7: Essential,</p>	<p>PA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the organisation in their preparation for</p>

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>Moderate</p>	<p>disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>Inspection of the fully equipped civil defence kit revealed this was easily accessible and its contents were being inspected two monthly. There is sufficient food but not enough stored water available for a maximum of 76 residents for three days in the event of a civil defence emergency; an improvement is required. During a regional area water shortage in 2019, the local council provided a water truck to the home. An onsite generator is available for use during power outages. This and the emergency lighting is checked for functionality monthly. Gas ovens and barbeques are available for cooking if there is no electricity. Surplus blankets are stored for warmth.</p> <p>The provider is still waiting for the NZ Fire and Emergency Services to issue approval of the reviewed fire evacuation scheme. This previously required corrective action is ongoing.</p> <p>Staff interviewed and records reviewed confirmed that fire drills were occurring six-monthly, the most recent being on 08 August this year. Results of the drills are sent to the Fire Service. The orientation programme includes fire and security training. Staff confirmed their awareness of essential emergency procedures.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells and this was observed.</p> <p>Appropriate security arrangements were in place. There are security stays on all windows, doors are locked and checked at 6pm and 9pm and a security company patrols 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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by electricity in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to</p>	<p>PA Low</p>	<p>Rangiura Rest Home 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 external infection control specialist.</p> <p>The registered nurse (RN) is the designated infection control coordinator (ICC), whose role and responsibilities are defined in the infection prevention and control policy. The ICC has been in the</p>

<p>the size and scope of the service.</p>		<p>position for three months. Infection control matters, including surveillance results, were reported monthly to the general manager and the CNL and tabled at the quality and risk committee meeting. This committee includes the CNL, ICC, health and safety officer, clinical team, the physiotherapist and representatives from food services and household management.</p> <p>There were posters at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. There was a room that was set aside for use by visitors during the Covid-19 pandemic period. 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>The annual review of the infection control programme has not been completed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC has appropriate skills, knowledge and qualifications for the role, and has been in this role for three months. The ICC has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. Resources sighted on the days of the audit include hand sanitisers around the facility, gloves, gowns, aprons and information on infection control measures were posted and accessible to residents and staff.</p> <p>Appropriate Covid-19 pandemic infection control monitoring measures were implemented as per Ministry of Health guidelines.</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</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed within the past two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education was provided by suitably qualified RNs and external infection control specialists. Content of the training was documented and evaluated to ensure it was relevant, current and understood. Records of attendance were maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this was when the Covid-19 pandemic started, additional staff education was conducted, and additional staff were being used to ensure social distancing for residents was maintained safely.</p> <p>Education with residents was on a one-to-one basis and in groups in residents' meetings, and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluid intake when there was an infection, for example, a urinary tract infections. This was verified in the records reviewed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance for infections was appropriate to that recommended for long term care facilities and included infections of the urinary tract, soft tissue, eye, influenza, gastro-intestinal, and the upper and lower respiratory tract. The ICC reviews all reported infections, and these were documented. New infections and any required management plans were discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identified trends for the current year, and this was reported to the CNL and infection control committee. Data was benchmarked externally with other aged care providers.</p> <p>There has been no infection outbreak reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The full time employed physiotherapist is the restraint coordinator. This person provides support and oversight for enabler and restraint use and demonstrated a good understanding of the organisation's policies,</p>

		<p>procedures and practice and her role and responsibilities.</p> <p>On the day of audit, eight residents were using lap belts and bed rails as restraints and seven residents were using the same, voluntarily and at their request as enablers. 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, files 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>	FA	<p>The restraint approval group, which comprises the physiotherapist/coordinator, CNL, a diversional therapist and either the GP or nurse practitioner, are responsible for approving use of restraints and the overall restraint process. The group meet at least every six months. Review of restraint approval group meeting minutes, and interviews with the coordinator confirmed clear lines of accountability, that all restraints had been approved, and that the overall use of restraints is being monitored and analysed monthly at multidisciplinary meetings.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was seen in the consent and assessment forms for each restraint.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the standard. The restraint coordinator who is a registered physiotherapist undertakes the initial assessment with sign off by an RN, and input from the resident's family/whānau/EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner or the nurse practitioner is involved in the final decision on the safety of the use of the 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 sample of restraint records reviewed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>The use of restraints was actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats and low beds, with fall out mattresses.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and</p>

		<p>respected. The monitoring forms do not reliably record off and on times for restraint or the interventions provided while a restraint is in place. An improvement is required</p> <p>The restraint register is maintained and updated as required. This is reviewed at each restraint approval group meeting. The register contained clear details about all the residents currently using restraints or enablers 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 restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed six monthly. This process focuses on the person, any changes in their condition and whether or not the restraint is still required. Two family members interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint approval group undertakes a six-monthly review of all restraint use which includes all the requirements of this standard. Interview with the restraint coordinator, minutes of these meetings and the results of internal audits confirmed that monitoring and quality review of overall restraint use is occurring. The review considers 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 any feedback from the GP/nurse practitioner, staff and families. Any changes to policies, guidelines, education and processes are implemented if indicated. Use of restraints is also discussed at the monthly multidisciplinary meetings and health and safety meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>Interviews and review of rosters showed there are four cleaners on site Monday to Friday who each work five or six hours. This includes a dedicated cleaner for the secure unit. One of those cleaners is expected to be the sole cleaner every fourth weekend. Although these are six hour shifts on a Saturday and Sunday, the main facility is very large and the secure unit has 16 bedrooms and a large communal area. Staff interviewed said that only the bare minimum of cleaning can be completed on the weekends, for example, vacuuming of common areas, emptying of rubbish bins and</p>	<p>The number of cleaning hours allocated over the weekend is insufficient for the size of the care home.</p>	<p>Ensure that sufficient hours and numbers of cleaning staff are provided during the weekend.</p> <p>60 days</p>

		toilet/bathroom cleaning.		
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	<p>There were three residents self-administering medications at the time of audit. Self-medication administration competency forms were completed initially when self-medication administration was approved. However, the recommended three-monthly reviews of residents' competency were not completed thereafter as per organisation's policy. All the overdue competencies were reviewed on the days of the audit, and the residents were assessed as competent. No adverse events were reported regarding self-medication administration.</p>	<p>All self-administration competencies were not reviewed three-monthly as per organisation's policy. Some were more than year overdue.</p>	<p>Ensure that the competency of the residents who administer their own medicines are reviewed three-monthly as per policy to ensure safety of residents.</p> <p>180 days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Moderate	<p>Changes to the building layout two years ago created a need for the evacuation scheme to be reviewed. This was identified at the October 2019 surveillance audit. The service provider has submitted two applications to the NZ Fire and Emergency Services in the past 11 months. The first application was declined, and they are waiting for an outcome from the second application.</p>	<p>The fire evacuation scheme has not been approved.</p>	<p>Obtain an approved fire evacuation scheme from the NZ Fire and Emergency Services.</p> <p>90 days</p>
<p>Criterion 1.4.7.4</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing.</p>	PA Moderate	<p>Interviews and site inspection revealed that changes in staff roles and responsibilities have resulted in an oversight with some aspects of the</p>	<p>There is insufficient water stored on site for the number of</p>	<p>Ensure there is as least 764 litres of clean and</p>

<p>(d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>		<p>care provided whilst the restraint was on was not always documented.</p>		<p>record of care or other events that occurred when the restraint was in place.</p> <p>180 days</p>
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Review of the annual and monthly plans for staff education and individual staff records reveal that every staff member is engaged with professional development and that they regularly attend in service education sessions. Staff expressed a high level of satisfaction with the staff training programme. The training coordinator collects, analyses and presents data on staff educational achievements every quarter. The overall rate of achievement is the highest it has ever been. The increase in staff knowledge and skills has resulted in an increase in care staff reporting changes in resident welfare and improvements to resident care.</p>	<p>The number of care staff who have achieved level 4 of the National Certificate in Health and Wellbeing has increased significantly from 16 to 40 in the past 12 months. There is a concurrent increase in the percentage of staff who are engaged in a career pathway.</p>

End of the report.