

# Te Kauwhata Retirement Trust Board - Aparangi Village Residential Care Unit

---

## 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:

<b>Legal entity:</b>	Te Kauwhata Retirement Trust Board
<b>Premises audited:</b>	Aparangi Village Residential Care Unit
<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: 16 November 2020    End date: 17 November 2020
<b>Proposed changes to current services (if any):</b>	Designate five previous rest home rooms as dual-purpose beds.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46



# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Aparangi Village Residential Care Unit provides rest home, and hospital level care for up to a maximum of 54 residents. The care unit and surrounding retirement village is owned and operated by the Te Kauwhata Retirement Trust Board. A new care unit manager (CM) who is a registered nurse (RN) was appointed following an issues-based audit in April 2020 which was instigated by the district health board (DHB). The CM is supported by two clinical nurse leaders (CNL) and reports to the recently appointed general manager (GM) who oversees business and operations for the entire site, including a large retirement village.

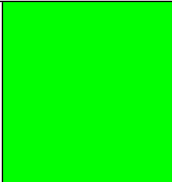
Significant work has been completed to address the issues identified during the issues based, follow up and financial audits. These are now fully resolved with the exception of the consumer information management system and update of the website. Solutions to address these were still in progress.

This recertification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, a general practitioner, contracted physiotherapist, nurse practitioner and a palliative care nurse. All interviewees spoke positively about the care and services provided.

This onsite audit also considered re configuration of previous rest home beds into dual purpose, and a whanau room converted for use as a palliative care suite. Observation and investigation, confirmed that the proposed configuration for a maximum 54 beds- a decrease of two rooms, 21 rooms designated for rest home use only, one room designated for respite/short stay and 32 bedrooms for dual purpose (rest home or hospital) was safe and suitable.

One new finding about not recording the effects of 'as needed' medicines was identified during this audit.

## Consumer rights

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

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

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

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

A complaints register is maintained and there was evidence that complaints are acknowledged, investigated and resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

The business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. An experienced and suitably qualified person manages the care facility.

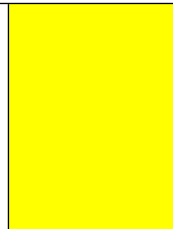
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Feedback on service delivery is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential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

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

Consumer information management systems are effective and meet the requirements. Both electronic and hard copy consumer records were in use.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Some standards applicable to this service partially attained and of low risk.

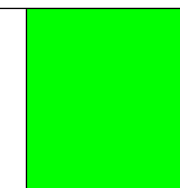
The admission process is appropriate and efficiently managed with relevant information provided to the potential resident/family. The multidisciplinary team, including registered nurses (RNs) and a general practitioner (GP), assess residents' needs on admission. Care plans are individualised, based on 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.

An electronic medication management system is used, and 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

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.
--	--	--


Systems for management of waste and hazardous substances are safe and effective. Staff were observed to be using protective equipment and clothing. Chemicals, soiled linen and equipment are safely secured. There was a current building warrant of fitness. All internal and external areas were easily accessible, clutter free, well maintained and meet the needs of residents. Electrical equipment and medical equipment are tested at least annually. Mobility equipment and furniture was in good condition and fit for purpose.

All areas of the home were being cleaned daily to a high standard. Except for some residents who prefer to do their own personal laundry, laundry is undertaken offsite and evaluated for effectiveness. Staff were attending regular training in emergency

procedures, use of emergency equipment and supplies. Security is maintained. The call bell system was functional and staff response to call bells is being monitored.

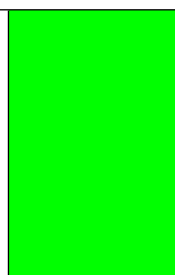
Communal and individual spaces are maintained at a comfortable temperature.

## 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.		Standards applicable to this service fully attained.
---	---	--

The organisation has implemented policies and procedures that support the minimisation of restraint. On the days of audit there were 10 residents who required bedrails or lap belts as either enablers or restraints, to keep them safe from harm.

## 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, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.



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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action 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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Aparangi Village Residential Care Unit has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff demonstrated knowledge and understanding of consumers' rights and obligations. Staff were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. The orientation process for all staff employed included the Code. Ongoing training on the Code is part of mandatory training scheduled on the annual education planner. This was verified in staff training records sampled.</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 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 is encouraged, and these plans were sighted in some records reviewed. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents' records. Staff were observed to gain verbal consent for day to day care. Other consent records sighted were for influenza vaccinations.</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>A copy of the Code, which also includes information on the Advocacy Service is provided in the admission pack. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Interviewed residents and family members were aware of the Advocacy Service, how to access this and residents' 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>	<p>FA</p>	<p>Interviewed residents and family members reported unrestricted visiting hours to the facility, though access is controlled after hours and the visitors can gain access through use of intercom. Family stated they felt welcome when they visited and comfortable in their encounters with staff when they visit. Staff support residents to access services within the community when appropriate, including attending to organised outings, visits, shopping trips and family can help with external appointments if available.</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 understood the process.</p> <p>The complaints register reviewed recorded three complaints from family members received this year. Acknowledgement, investigations and actions taken, through to an agreed resolution, are documented and completed within the timeframes stated in policy. There have been no known complaints received by the Office of the Health and Disability Commissioner or the DHB since the previous audit. One complaint was still being investigated and remained open at the time of this audit.</p> <p>The CM is responsible for complaints management and follow up, with final signoff by the GM. All complaints are reported at board level monthly as confirmed in meeting minutes and reports sighted.</p> <p>The staff, residents and family members interviewed demonstrated knowledge and understanding of the complaint process and the procedures associated with complaints/concerns.</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 the admitting RNs. The Code, both in English and Maori languages was displayed on the notice boards around the facility together with information on advocacy services, how to make a complaint and feedback forms. There was a complaints box near the reception area that is accessible to residents</p>

		and family.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Residents' personal clothes were labelled with residents' names for easy identification. Staff were observed to maintain privacy throughout the audit by providing personal cares behind closed doors. All residents have a private room and there was one couple who share a room with their spouse.</p> <p>Residents are encouraged to maintain their independence to attend to community activities and participation in clubs of their choosing. Reviewed 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 as part of the mandatory training for all staff annually. Interviewed family members confirmed that they have not witnessed or suspected any abuse or neglect.</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>On the days of the audit, there was one resident who identified as Maori. The resident and their family reported that staff acknowledge and respect their individual cultural needs. There were five staff who identify as Maori and the service has engaged a kaumatua who supports with cultural advice. Barriers to access appropriate services were identified and eliminated where possible. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</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</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.</p>

and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, and mental health services for older persons, and education of staff. The general practitioner (GP) and nurse practitioner confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Online training is available for all staff through Ko Awatea.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. The residents and their family where appropriate, reported their involvement in three monthly reviews with the GP and the nursing team. This was evident 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.  Staff knew how to access interpreter services through the local district health board, although reported this was rarely required due to all residents able to speak English; staff able to provide interpretation as and when needed and the use of family members.
Standard 1.2.1: Governance The governing body of the	FA	A three-year (2021-2024) business plans outlines the vision, values, missions, and goals of the organisation. The document describes strength, opportunities, weakness and threats, objectives and key priorities. Interview with the board chairperson, the general manager (GM) and CM confirmed that

<p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>business goals and other operational matters are discussed at monthly board meetings. This was also verified in the sample of board reports reviewed. The new general manager who commenced the role on 24 August 2020 is responsible for village management, financial and site development. The CM reports to the GM. Senior management and the board chair confirmed that the reviewed organisational structure and communication methods are effective. Communication between the board and the care facility is occurring in a timely manner via the GM.</p> <p>The CM holds a current nursing practising certificate and has long term clinical and aged care management experience. This person has been in the role since early May 2020. Responsibilities and accountabilities are now defined in a job description and individual employment agreement. Both managers confirmed knowledge of the sector, regulatory and reporting requirements and they maintain currency through online education and regular sector meetings. For example, the DHB Aged residential care (ARC) meetings when they resume, and liaison with other aged care facility managers. Aparangi Village Residential Care Centre (Aparangi) continues as a member of the Community Trust Care Association (CTCA) group. CTCA is a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations.</p> <p>The organisation holds agreements with the DHB for aged residential care (ARC) in rest home, hospital, medical, respite and palliative care, Long Term Support-Chronic Health Conditions (LTS-CHC) and the Ministry of Health (MoH) for Young People with Disabilities (YPD). There is also a contract for a community day activities programme.</p> <p>On the day of audit 46 of the 54 beds were occupied. Twenty-seven residents were receiving rest home level care, one person was on short term respite and 17 residents were receiving hospital care, plus another person was palliative. Two people were under 65 years of age one under MoH YPD and one under LTS-CHC. One was receiving rest home level care and the other hospital level care.</p> <p>The service sought to reconfigure its service with the Ministry of Health (MoH) in October 2020 by applying for five additional hospital beds. Changes within the current layout have occurred in order to cluster hospital and palliative care rooms. The current desired configuration is 32 dual purpose rooms (11 designated hospital) and 21 rest home beds plus one respite room - total 54 beds. This takes into account the previous seven occupation right agreement (ORA) apartments within the care unit which had been approved for rest home care in 2014. The organisation is buying back these apartments as they become available for use as care beds. Five are still under an ORA, two of which are occupied by people receiving care services.</p> <p>A previous quiet room has been refurbished and re-designated for hospital care. All 32 hospital/dual purpose rooms inspected were sufficiently sized to accommodate mobility equipment or had ceiling hoists installed. Installation of ceiling hoists in all dual-purpose bedrooms has been approved by the board. The rooms are all in close proximity to the nursing station, sluice room and common dining and activity areas. All have hand basins and toilets or full ensuite bathrooms and/or proximity to shower bed bathrooms. More</p>
---	---

		information is described in Outcome 1.4
<p><b>Standard 1.2.2: Service Management</b></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>Planned and unplanned absences of the CM are covered by one of the CNLs with support from the GM. Their clinical responsibilities are covered temporarily by the other CNL with support from other senior RN's. Staff reported these arrangements work well.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Significant work has occurred since the April 2020 issues based audit, to re-establish effective quality and risk management systems. All levels of staff and the board are regularly informed about how the service is performing according to its quality and risk monitoring. The system includes gathering essential quality data from complaints, resident and relative feedback, adverse event reports, the outcomes of internal auditing, infection events and restraint activity. All adverse events such as falls - witnessed and unwitnessed - causing injury or no injury; skin tears, behaviours of concern, pressure injuries, and medicine errors are collated, analysed for trended and then reported to all staff with remedial actions to prevent recurrence. Neurological observations after unwitnessed falls are reliably occurring.</p> <p>There is a full suite of sector standardised policies and procedures which cover all aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The policies are based on best practice, and have been personalised to reflect Aparangi Village Residential Care Centre. The policies which were required as a result of the DHB audits, for example, financial management policies, communication protocols, and website and electronic use policy, have been completed, ratified by the board and are now implemented. These corrective actions are now closed.</p> <p>The document control system provides a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Aparangi/Te Kauwhata Trust Board is continuing its membership with the Community Trust Care Association (CTCA) and the benefits its gains from bulk purchasing, sharing staff training and management expertise, following the same policies and procedures and benchmarking between the nine aged care facilities who are members.</p> <p>Feedback reviewed from the August 2020 resident and family satisfaction surveys and the monthly</p>

		<p>residents' meetings revealed a moderate to high level of satisfaction and no major areas of concern. This information, adverse event data and the results of internal audits are reported to a clinical governance group/board subcommittee monthly. Where areas for improvement are identified, corrective action plans are being documented by the clinical leaders and the care manager. The actions required are monitored to ensure implementation and that the desired effects have occurred.</p> <p>The CM notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings.</p> <p>There is an up to date risk management plan and hazard register which are monitored by the GM, CM and members of the health and safety committee, and any risks are reported to the board. Senior staff and the health and safety team are familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</p> <p>Previous concerns and areas for improvement with regard to quality and risk management systems are now addressed. Updates to the website are in progress but are still to be completed.</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 accident/incident 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. Each event form recorded that families or significant others had been notified and family members interviewed confirmed they were being kept informed.</p> <p>Adverse event data is collated, analysed and reported to the senior management team manually. The electronic system in use does not alert the CNLs or care manager of new incidents, which has been a source of ongoing frustration and in one situation led to a response delay for remediating signs of skin breakdown. The organisation has prioritised purchase of new software but procurement has been interrupted by the series of lockdowns this year. All incidents are being clearly reported up at handovers, in the interim as a risk mitigation measure. A summary of adverse events is reported at board level monthly.</p> <p>The CM and GM understand and adhere to essential notification reporting requirements. They advised the only section 31 essential notification reports since April this year were for notifying changes in management and shortage of RNs.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of</p>



<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>qualifications and practising certificates (APCs), where required.</p> <p>The position descriptions identified as needing to be developed for the CM, executive administrator and financial administrator roles, have been completed. These were reviewed and verified as suitable. The previous corrective actions are now closed.</p> <p>A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-weeks and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Mandatory training days cover the Code of Consumer Rights, chemical safety, incontinence, falls prevention, manual handling, managing challenging behaviour and restraint minimisation, infection prevention and control, health and safety and fire and emergency readiness.</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. Of the 42 care staff, twenty eight are currently enrolled with Careerforce and progressing the national certificate in health and wellness. Five people have achieved level four, 12 are at level three and two are at level two. Only one carer is at level four due to their length of service. Seven of eight RNs employed are maintaining their annual competency requirements to undertake interRAI assessments, as are the two CNLs. There is also one enrolled nurse employed. The staff records sampled demonstrated completion of the required training and that annual performance appraisals were up to date.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented process for determining staffing levels and skill mixes which was reflected in the rosters reviewed.</p> <p>The care manager described how staffing levels are adjusted to meet the changing acuity level of residents, including use of interRAI information, to support staffing decisions. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff on morning and afternoon duty reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Bureau staff have had to be used to cover one to two night shifts shortages of RNs each week for the past two months. This has been reported via section 31 notifications. This has been resolved by implementing a rotating shift roster for all RNs and recruitment for night-time RNs is ongoing.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week</p>

		RN coverage in the facility. Observations and review of a four week roster cycle confirmed adequate staff cover has been provided for morning and afternoon shifts, with staff replaced in any unplanned absence across all shifts. The CM advised that they are maintaining an adequate casual pool of staff.
<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>Aparangi Village Residential Care Unit uses an electronic information management system with a backup of a paper-based system in case of emergencies when the electronic system cannot be accessed. The electronic information management system is supported by paper-based system for some records still in use, for example incident/adverse event forms are paper based. Reviewed records demonstrated that documentation was accurate and was entered in the system in a timely manner by all staff. The carers were observed using i-pads and have individual passwords to access the electronic system.</p> <p>Residents' files were stored in secure locked cupboards in the nurses' station. All reviewed records were legible with the name and designation of the person making the entry identifiable. There is a current staff signature register in place. Residents' records were integrated to include the GP, nursing staff, activities, physiotherapy and other specialist services' notes in the files reviewed.</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>Records reviewed confirmed that residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission. Written information about the service and the admission process is provided to the prospective residents and/or their family prior to admission in the enquiry pack. The facility manager, clinical nurse leader (CNL) or the admitting RNs explain the entry process to the prospective residents. Updated information from the NASC and the GP is requested for residents accessing respite care; respite care records reviewed verified this.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or</p>	FA	<p>The RNs manage the exit, discharge or transfer of residents with the support of the CNLs, with an escort provided 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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals were documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility demonstrated that</p>

transfer from services.		adequate information was shared with the receiving service to promote continuity resident's care. The resident's family reported being kept well informed during the transfer of their relative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. This was verified in the referral records sighted. There is a clause in the admission agreement related to when a resident's placement can be terminated.
<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>	PA Low	<p>Aparangi Village Residential Care Unit has a documented policy on the management of the medication system. An electronic medication management system is in use. All staff who administer medication have individual passwords to access the electronic medication records. Allergies were documented, identification photos were present and three-monthly reviews were completed. The RN was observed administering medication correctly. All staff who administer medicines had current medication administration competencies. The medication administration competencies are renewed annually.</p> <p>The RNs conduct the medication reconciliation when residents are readmitted from acute services, for new admissions or when there are any medication changes. There is a contracted pharmacy that supplies medication to the service in a pre-packaged format. The packs received from the pharmacy are checked by RNs and recorded on the electronic medication management system.</p> <p>There were controlled drugs kept onsite. The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted, and all medications were stored appropriately. Medication audits were conducted, and corrective actions have been acted on. Monitoring of the medication fridge and the room temperature were conducted.</p> <p>There were no residents self-administering medication on the days of the audit. There is a policy and procedure for self-administration of medication if required.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management policy complies with legislation, protocols and guidelines; however some administered PRN medicines were not evaluated for effectiveness.</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</p>	FA	<p>The support services supervisor is responsible for all aspects of food procurement through food wholesaler in consultation with the cooks. The food service is provided on site by three cooks and kitchen assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four-week 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 preparation, storage, transportation, delivery and disposal comply with current</p>

component of service delivery.		<p>legislation and guidelines. The service operates with an approved and current food safety plan and registration issued by Waikato City Council. Food temperatures, including for high risk items, were monitored appropriately and recorded as part of the plan. The cooks have safe food handling qualifications, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Copies of the diet profiles were sighted in the kitchen folder. Special equipment, to meet resident's 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. On the days of the audit, 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>Repairs have occurred to the ceiling of the kitchenette used for serving residents' meals. The laundry washing machine installed in this room has been decommissioned. These corrective actions are now complete.</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>	FA	<p>The CNL stated that when a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The prospective resident and/or their family of choice are informed of the reason for the decline of entry to the service and other options or alternative services. Examples of this occurring were discussed with the CNL. Inquiry records were maintained and follow up conducted and a record of the declined referrals were sighted.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The needs, outcomes and residents' goals were identified via the assessment process and documented in the electronic and paper-based assessment records reviewed. Validated nursing assessment tools, such as, a pain scale, falls risk, skin integrity, nutritional screening, continence and activities of daily living needs, were used as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Reviewed residents' records had current interRAI assessments completed and identified needs supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p>
Standard 1.3.5: Planning	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and 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. Residents' individual needs were evident in the service provided. The GP, nurse practitioner, physiotherapist and mental health specialist interviewed, verified that expert input was sought in a timely manner, that recommended interventions were followed, and care was implemented promptly. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one trained diversional therapist (DT) holding the national Certificate in Diversional Therapy, and two activities assistants.</p> <p>A social assessment and history form is included in the pre-entry information provided to residents and family or residents complete it before admission or the staff can complete it within the first week of admission. Information gathered is to ascertain residents' needs, interests, abilities and social requirements. The DT is responsible for completing the activities care plan with the help of the activities assistants. Daily activities attendance records were maintained. The activities programme was regularly discussed in the residents' meetings and assessed as part of the residents' satisfaction surveys to help formulate an activities programme that is meaningful to the residents. The residents' activity needs were evaluated regularly as part of the formal six-monthly care plan review.</p> <p>Residents' activities records reviewed reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Planned activities included birthday celebrations, monthly theme celebrations, bingo, church services, van outings, music, board games, external entertainment, exercises, men's outings and pampering sessions for women. Residents were observed participating in a variety of activities on the days of the audit. The interviewed residents confirmed they find the programme satisfactory.</p> <p>Individual activities were offered for younger residents including support to attend to external community activities. The interviewed resident reported satisfaction with the activities provided for younger residents.</p>

		The residents stated that they can join in the entertainment sessions and any other group activities of choice.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>The reviewed residents' records evidenced that long-term care plans were conducted six-monthly following six-monthly interRAI reassessments. Where there was a significant change of residents' condition, the interRAI reassessments was completed to reflect the residents' current condition and care plan updated. Where the residents' required goals were not achieved, the service responded by initiating changes to the plan of care. Carers evaluate residents' care on each shift and document in the progress notes. Changes noted were reported to the RNs and this was verified in the residents' records reviewed.</p> <p>Short-term care plans were implemented for acute conditions, such as urinary tract infections, chest infections, eye infections and wound infections. These were being consistently reviewed and progress evaluated as clinically indicated. Residents and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes during six-monthly multidisciplinary review meetings and three-monthly reviews.</p>
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents were given the choice and advised of options to access other health and disability services where indicated or requested. This information was clearly indicated on the signed informed consent forms sighted in residents' files sampled. Residents may choose to use another medical practitioner if they wish to. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the palliative care/hospice team, mental health team, dentists and urologists. The residents 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 acute services in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances,	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. There is known secure storage areas for waste. Recycling occurs and includes fat, oil and plastic. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide regular training for all staff.</p> <p>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 sufficient supplies of personal protective equipment (PPE) on site and staff were observed to</p>

<p>generated during service delivery.</p>		<p>be using these appropriately. All staff have attended training on the correct procedures for donning and doffing PPE.</p> <p>Refurbishment of the sluice room identified as needing an upgrade earlier this year, has occurred. This corrective action is now resolved.</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 (expiry date 22 April 2021) is 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 (June 2020) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>The environment was hazard free, residents were safe and independence was promoted. The service had adequate lifting equipment, including ceiling hoists, in the majority of hospital bedrooms with plans to install these in all of the 32 proposed dual-purpose rooms.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. All external areas have seating and shaded areas for resident use.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility.</p> <p>All bedrooms have a hand basin. Twenty-two rooms have full ensuite bathrooms and the other 32 have toilets. Hot water temperature monitoring of all water outlets occurs monthly. Hot water temperatures are moderated by tempering valves and the records showed that temperatures were within the safe range, no hotter than 45 degrees Celsius in resident areas and 60 degrees in the kitchen and sluice areas.</p> <p>There are separate staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>The bathroom that required repair to a leaking ceiling is now fit for purpose. Remedial work to the bathroom which houses the shower bed and hair salon is planned but building work cannot commence until March 2021. The bathroom is adequate and poses no threat to resident safety in the meantime.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</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. Bedrooms are personalised with furnishings, photos</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>and other personal items displayed. All bedroom doors are wide enough to use mobile lifting equipment to go into the room and all bedrooms are of adequate size for the resident group, either rest home or hospital level care.</p> <p>Visual inspection of all areas confirmed the safety and appropriateness of increasing the number of bedrooms approved for dual purpose use. The overall number of rooms in use has decreased by two to a maximum of 54 bedrooms. Twenty-two of these are considered as suitable for rest home use only which included one room dedicated for short stay/respice. The location and size of the other 32 rooms which have toilets or full ensuite bathrooms, hand basins, electric beds and ceiling hoists (except for 10) make these suitable for either rest home or hospital level care/dual purpose. One of these rooms is dedicated for palliative care.</p> <p>The facility provides space for storage of mobility aids and wheelchairs. There is a dedicated mobility scooter bay which allows all scooters to be charged when not in use.</p> <p>Staff and residents reported the adequacy of 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>Two dining rooms and a number of lounge/recreational areas are appropriately furnished and located within close walking distance for residents. Residents have access to a range of internal and external areas for privacy, if required. All of the residents interviewed were happy with the areas provided.</p> <p>Residents may also access Simmonds Hall and its library, the retirement village common room which is adjacent to the care facility. The hall is used by village residents for a range of meetings and activities.</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 services are provided off-site although there is a small laundry area available for residents who wish to continue doing their own clothes washing.</p> <p>There have been some issues with the outsourcing of resident's personal laundry to the extent where Aparangi are considering their options for laundry services. Establishing a new laundry area to provide laundry services on site is under investigation.</p> <p>Two cleaners are on site for 6.5 hours Monday to Friday with a third cleaner rostered on each Wednesday. One cleaner is allocated the same hours on Saturdays and Sundays. All cleaning staff are receiving ongoing training including the New Zealand Qualifications Authority Certificate in Cleaning (Level 2).</p> <p>Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme with monthly checks being</p>



		conducted as part of the environmental audits. Visual checks are undertaken of laundry daily when it is unpacked.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The fire evacuation scheme was reviewed and approved by Fire and Emergency New Zealand on the 14 October 2020. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 10 November 2020.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for 54 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. Water storage tanks are located around the complex, and there is now a petrol operated generator on site. The generator is capable of running for 8 hours on 1 tank. Sufficient fuel for 3 days running is stored on site. The generator will run outside the building and is not wired in to the main power grid. It provides enough power to run oxygen generators and sustain life and keep the medications fridges running. The provider conducts test runs and records the results of the test monthly. The previous corrective action related to this is now closed.</p> <p>Emergency lighting is regularly tested</p> <p>Call bells alert staff to residents requiring assistance and allows for the response times to be monitored. A random call bell test during the audit was responded to within six minutes. However, residents and families said that staff usually respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a voluntary community security patrol checks the premises each night at random times.</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</p>	FA	<p>Residents' rooms and communal areas are heated and ventilated appropriately. Each room has adequate natural light, opening external windows and many have doors that open onto outside garden areas. Heating is provided by hot water radiators with thermostats located in each resident's bedroom and in the communal areas. There are also heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a</p>

that is maintained at a safe and comfortable temperature.		comfortable temperature.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Aparangi Village Residential Care Unit 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 infection control specialist service. The infection control programme was reviewed in September 2020 and an annual review is planned.</p> <p>The CNL is the designated infection prevention and control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, were reported monthly to the facility manager, and tabled at the monthly staff meetings.</p> <p>Signage was posted at the main entrance to the facility that requests anyone who is or has been unwell in the past 48 hours with an infectious condition, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Covid-19 pandemic infection control recommendations from the Ministry of Health were implemented and current information was posted around the facility including maintaining a visitors' register for contact tracing.</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 and 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. Adequate resources were sighted on the days of the audit.</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</p>	FA	<p>The infection prevention and control policies were current and reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in September 2020 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>

available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided as part of the induction process for new staff and as mandatory training scheduled annually. Content of the training was documented and evaluated to ensure it is relevant, current and understood. A record of attendance was maintained. The ICC reported that when there is an infection outbreak or an increase in infection incidence has occurred, additional staff education has been provided in response. Additional staff education was provided during the Covid-19 pandemic period including hand hygiene, use of personal protective equipment, social distancing and increased monitoring of residents through daily symptom checks.</p> <p>One-to-one education was provided to residents when required and has included reminders about hand washing, advice about remaining in their room when they were unwell and good hygiene. This was verified in the short-term care plans reviewed.</p> <p>Infection prevention and control education is provided by the ICC.</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>Infection surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, 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 plan were discussed at handover, to ensure early intervention occurs. Regular infection prevention and control audits were conducted, and corrective actions were implemented as required.</p> <p>Monthly surveillance data is 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 identify trends for the current year, and comparisons against previous months and this was reported to the facility manager and the facility manager reports to the board. 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</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.</p> <p>One of the CNL's is the restraint coordinator. This person provides support and oversight for enabler and</p>

<p>use of restraint is actively minimised.</p>		<p>restraint management in the facility and demonstrated understanding of the role and responsibilities.</p> <p>On the day of audit, seven residents were using restraints (bedrails, safety belts when seated and a fall out chair) and three residents were using bedrails as enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident by observation of residents, their files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the restraint coordinator, registered nurse and GP or nurse practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored.</p> <p>Evidence of family/whanau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator or another RN undertakes the initial assessment with the involvement, and input from the resident's family/whanau/EPOA. The restraint coordinator and RN interviewed described the documented process. Families confirmed their involvement. The general practitioner or nurse practitioner are 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 all of the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, such as the use of sensor mats and low beds. Use of these was also observed on audit. Policy states that when restraints are in use, monitoring timeframes are identified according to the level of risk but never more than two hourly intervals. Monitoring records for each of the files sampled met the timeframes and expected requirements. Access to advocacy is provided</p>

		<p>if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated and reported at staff and RN meetings every month. The register was reviewed and contained all residents currently using a restraint. 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 understand 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 and evaluated during interRAI reviews, and by the restraint approval group. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The documented evaluation process meets the 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 coordinator completes a quality review of all restraint use which includes all the requirements of this Standard. This is reported up to the CM and all RNs at least six monthly. The review includes analysis and evaluation of the amount of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the RNs, staff and families. A six-monthly internal audit that is carried out also informs the review. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, meeting minutes and interviews with the restraint coordinator confirmed that the use of restraint is being minimised.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The medicine management policy provides guidelines for the management of pro-re nata (PRN) medication. PRN medication is administered when required and associated documentation is completed on the electronic system. The effectiveness of some administered PRN medicines was not consistently monitored and documented.	Eleven out of the 14 sampled medication charts did not have evaluations of the administered PRN medication documented.	<p>Ensure that PRN medication administration protocols and guidelines are adhered to.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
--------------------

End of the report.