

Norfolk Lodge Waitara Limited - Norfolk Lodge Rest Home

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 BSI Group New Zealand Ltd, 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: Norfolk Lodge Waitara Limited

Premises audited: Norfolk Lodge Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 18 January 2021 End date: 19 January 2021

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: 28

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

Norfolk Lodge rest home is privately owned and provides rest home and dementia level care for up to 40 residents. On the day of the audit there were 28 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, general practitioner and staff.

The manager is a registered nurse and has been in the role for 16 years. She is supported by an experienced part-time registered nurse, quality assurance coordinator/administrator, senior healthcare assistants and a stable workforce. Residents and family interviewed were very complimentary of the services and holistic care provided in a homely, family environment.

There were no areas for improvement at this certification.

The service has been awarded a continuous improvement rating around community links and reduction of urinary tract infections.

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.

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

Norfolk Lodge provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents are encouraged to maintain former links with the community. There are a number of community and cultural visitors to the home.

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 plan, quality and risk management plan and quality and risk policies describe Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external

training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care in the rest home and dementia unit.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

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.

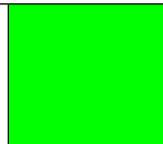


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. All rooms are single, and all have a hand basin. All toilets and showers are communal. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services. All staff are trained in first aid.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. There were no residents using enablers and two residents with restraint. The restraint coordinator monitors restraint documentation and compliance. Staff receive regular education and training on restraint minimisation.

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.

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The manager/registered nurse is the infection control coordinator. The infection control coordinator has attended external education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	2	48	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and care staff interviewed (one manager/registered nurse, one registered nurse, three healthcare assistants [HCA], one diversional therapist and one activity assistant) could describe how the Code is incorporated into the residents' daily activities of living. Staff receive training about the Code during their induction and as part of their two-yearly training plan last in October 2020.</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</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (four rest home including one ACC rehabilitation respite care and one long-term chronic health care (LTS-CHC) and three dementia including one respite dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the dementia unit all resident files reviewed had activated EPOAs.</p>

to make informed choices and give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services. The visiting reverend is available at any time as a resident advocate. The service has a volunteer resident advocate (present on the days of audit). Advocacy services are displayed in the main entrance. There is an Alzheimer's Society information board in the entrance of the dementia care unit and there are monthly external Alzheimer support group meetings for family who wish to attend.</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>	CI	<p>The service encourages their residents to maintain their relationships with friends/whānau and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the diversional therapy team and staff to ensure that the residents continue to participate in their chosen community group. The service has been successful in accessing community links for both Māori and non-Māori residents.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. Complaints forms are visible and available at the entrance of the facility. Residents and families interviewed were aware of the complaints process. The complaints policy and form are included in the welcome pack. A compliment and complaint register are maintained. The privacy officer (manager/RN) leads the investigation of any concerns/complaints in consultation with relevant staff for clinical concerns/complaints. Concerns/complaints and compliments are discussed at the monthly staff meeting and evidenced in meeting minutes. There have been no complaints since the previous audit.</p> <p>The manager/RN has completed an online Privacy Commissioner course.</p>
Standard 1.1.2:	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information

<p>Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>welcome pack that is provided to new residents and their families. The manager/RN discusses aspects of the Code with residents and their family on admission. The Code of Rights is displayed and there are Code of Rights and advocacy brochures readily available. Five rest home residents and four family members (two rest home and two of dementia care residents) reported that the residents' rights were being upheld by the service.</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>Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed, and observations during the audit, confirmed that the residents' privacy is respected. All staff were observed to be respectful and caring towards the residents. Residents and relatives confirmed staff respected the resident's individual values and beliefs. Healthcare assistants reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. There are privacy signs on communal toilet doors and shower rooms. The residents' personal belongings are used to decorate their rooms. Guidelines on abuse and neglect are documented in policy. Staff have attended education and training on abuse and 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>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care for any residents who identify with Māori. Cultural values and beliefs are identified on admission through resident and whānau consultation. There are 13 residents (50%) who identify as Māori. The Māori Health Plan including protocols on dying and death is incorporated in the long-term care plan as sighted in three Māori resident files. The service incorporates the principles of Te Tiriti O Waitangi and recognition of Māori cultural values and beliefs across all areas of service delivery including communication, language, care, recreation, spirituality and foods. The manager/RN has been acknowledged for her involvement and contribution to the review of Māori cultural policies for an aged care consultant. The part-time RN is a tutor at a tertiary learning centre and has almost completed a Masters in Indigenous People. Over 50% of staff identify with Māori and speak fluent te reo Māori. Karakia and waiata are part of the staff daily practices for residents who wish to participate. During Covid-19 lockdown residents were able to continue their learning of te reo Māori with their local kohanga Māori based childcare service, who provided morning sessions online for residents. One owner/director who identifies as Māori lived on site for five weeks during lockdown to provide support for residents, whānau and staff.</p> <p>The service has strong community links and relationships with other Māori services including the local iwi, hapu, marae, iwi radio station, Tui Ora and the local kapa haka group. There is a visiting Māori reverend who offers cultural support for whānau, residents and staff. Two Māori residents and two Māori relatives interviewed confirmed</p>

		the service is meeting Māori culture, values and beliefs and the staff are very respectful of their kuia and kaumatua residing at the facility.
<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>	FA	<p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission in consultation with the resident and family. Beliefs and values are incorporated into the residents' care plans. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual cultural and spiritual values and beliefs. Residents have access to spiritual visitors and there are church services held on site.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Employees sign a code of confidentiality on appointment. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the HCAs' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Good practice is promoted and practiced around the provision of holistic quality care and services provided at Norfolk Lodge. Policies have been developed by an aged care consultant in line with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. The service has employed a quality assurance coordinator/administrator to oversee a range of quality improvement projects. There are long-serving staff who know the residents well. The care staff interviewed were knowledgeable about their role and the residents they were caring for. Care staff confirmed on interview they feel supported and their contribution into resident care is valued. Staff in all areas of service delivery are well educated with HCAs all qualified at level 3 or level 4. There is a qualified diversional therapist (DT) and one activity coordinator (based in the dementia care unit) who is progressing through DT qualifications. Both chefs have marae catering food services certificates. Care staff (including the RNs) have recently gained skills and knowledge around nasogastric feeding to</p>

		<p>be able to provide nutritional requirements for a resident returning from hospital requiring this. Training was completed at the DHB with the clinical nurse specialist which was followed up at the facility. All care staff were deemed competent to perform this procedure and have been able to provide cares for respite residents also requiring nasogastric feeds. The service is supported by an aged care DHB clinical nurse specialist, mental health services, hospice and other allied health professionals as required. Residents and family interviewed were very satisfied with the care and services provided. The owner/directors have engaged the advice of a dementia care specialist regarding refurbishment and decor for the dementia care unit in-keeping with best practice for a dementia care environment.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The welcome pack includes specific information for dementia care. The manager/RN operates an open-door policy and completes a daily round promoting open communication for residents, relatives and staff. There are at least two resident meetings per year where family are invited to attend. The service has a Facebook page and skype available to families. During Covid-19 lockdown there were regular zoom meetings with family members and their relative. Relatives interviewed stated they were kept well informed on their relative's health and Covid-19 restrictions.</p> <p>Six incident/accident forms reviewed for December 2020 identified family were notified following a resident incident. Family members interviewed confirmed they are notified promptly of any incidents/accidents.</p> <p>Interpreter services are available if required. There are many staff who are able to converse in fluent te reo Māori.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Norfolk Lodge is privately owned by two owner/directors for almost four years. The rest home provides care for up to 23 rest home level residents and 17 dementia level of care residents. On the day of audit there were 15 rest home residents (including one younger person under ACC funding, one younger person under long-term chronic health condition – LTS-CHC contract, two residents under short-term ACC rehabilitation respite and one resident under respite care) and 13 dementia level of care residents including one resident for respite care. There was one dementia care resident awaiting a needs assessment for higher level of care.</p> <p>Norfolk Lodge's mission and philosophy is identified in the strategic business plan, which is reviewed annually against the goals and records achievements to date. The 2021 strategic business plan is in the process of being developed in consultation with the management team. Goals include falls prevention strategies, increasing occupancy and providing a dementia support group for families. One owner/director was present on the day of audit. The directors who live outside of the region visit at least monthly and receive staff meeting minutes monthly. There are monthly video chats with the management team and regular email correspondence with the manager/RN.</p>

		<p>The owner/directors receive HealthCERT updates and are members of an aged care association.</p> <p>The manager is a registered nurse (RN) who has been in the role at Norfolk Lodge for 16 years. She is supported by a part-time RN five hours a week (4-5pm Monday to Friday) and a quality assurance coordinator/administrator and long-serving senior staff.</p> <p>The manager/RN has attended at least eight hours of education within the last year related to managing a rest home including interRAI competency refresher, DHB study day on Older and Vulnerable adults, advance care planning/enduring power of attorney and end of life education. The manager/RN attends the quarterly Leadership in aged Care forums at the DHB which includes an education session. She also attends and presents at on site in-service for staff. The manager/RN is a qualified cognitive examination assessor (July 2020) and has completed online training and face-to-face preceptor course at the learning centre (WITT) to supervise and assess nurses on site while completing their competency assessment programme.</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 part-time RN covers the manager/RN leave. The manager/RN and part-time RN provide afterhours cover.</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</p>	FA	<p>The quality and risk management plan and quality and risk policies describe Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an aged care consultant who reviews policies to ensure they align with current good practice and meet legislative requirements. Staff are informed of any reviewed/new policies at staff meetings and are required to sign that they have read them. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, restraint use, surveys and complaints management. Data that is collected is analysed and compared monthly and annually for a range of adverse event data. There is documented discussion of quality data, analysis, trending and corrective actions in the staff meeting minutes. Infection control and health and safety is included in the staff meeting. Meeting minutes are made available to staff and staff sign to state they have read the minutes.</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>The quality assurance coordinator oversees the internal audit programme and allocates audits (clinical and non-clinical to the appropriate person) which have been completed as per the annual internal audit schedule. Clinical audits are completed by an RN. An audit action summary form is maintained with audit results and any areas identified for corrective actions. Where improvements are identified, corrective actions are developed, implemented and regularly evaluated. Information is shared with all staff as confirmed during interviews.</p> <p>Annual resident/relative satisfaction surveys are completed annually. An on-line survey was sent out August 2020 with a low return rate. Relatives rang/emailed their feedback to the service. The online response combined with written feedback demonstrated 100% satisfaction with care and communication. The service completes six-week post admission surveys for all new residents and implement changes as required. All residents and families interviewed were very satisfied with the care and services provided.</p> <p>The maintenance person is the health and safety representative. The health and safety representative completes facility walk-arounds checking for potential hazards and free egress near exit doors. He ensures all contractors and new staff complete health and safety inductions. All staff complete an annual health and safety questionnaire and attend health and safety/hazard management education as scheduled. The health and safety representative provides a monthly report to the staff meeting. The health and safety representative and manager/RN are registered to attend a two-day health and safety course in April 2021. There is a current hazard register which is reviewed six- monthly.</p> <p>Falls management strategies include sensor mats, and interventions are documented in individualised care plans to meet the needs of each resident who is at risk of falling. The service is currently trialling bed sensors in the dementia care unit.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident including falls, skin tears, bruises, behaviours of concern and absconding. There is timely RN assessment including after hours for accident/incidents. Incident/accident data is collated monthly and analysed for time, location, frequent fallers and preventive actions. Incidents/accidents are discussed daily with the team and reported at the staff meeting (sighted in meeting minutes). Six accident/incident forms (four rest home and three dementia care) for December 2020 were reviewed including three unwitnessed falls, one witnessed fall and two skin tears. Each incident involved a resident RN clinical assessment, relative notification, monitoring required and corrective actions. Neurological observations were completed for one resident with an obvious knock to the head. CCTV footage is reviewed for each unwitnessed incident/accident to determine if there has been a head injury or other injury requiring monitoring/treatment.</p> <p>The manager/RN, owner/director and quality assurance coordinator (interviewed) were aware of reporting requirements for essential notifications. There have been no incidents to report to HealthCERT.</p>

manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files sampled (one RN, two HCAs, one activity coordinator, one quality assurance coordinator and one cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current for those staff employed over one year. Current practising certificates were sighted for the manager/RN, relieving RN and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Staff are required to complete a generic orientation which includes health and safety/fire safety, infection control, policies and procedures related to the service. Staff then complete a role-specific orientation. A two-yearly education plan covers all mandatory educational requirements however not all training over the lockdown period has been completed due to Covid-19 restrictions. There has been additional onsite infection control and Covid-19 education including handwashing, use of personal protective equipment and outbreak management. Attendance records evidenced good attendance at education. Staff have the opportunity to attend external education such DHB study days. External speakers provide education such as Age Concern, health and disability advocate and hospice. The part-time RN has completed mental health papers and provides training on dementia and behaviours of concern. Staff complete competencies relevant to their roles such as medication (including insulin and warfarin), restraint, skin integrity, care of sharps and hoist use.</p> <p>The service has three Careerforce assessors (one DT and two senior HCAs). Fifteen of 16 HCAs have completed the required dementia unit standards. Nine HCAs work in the dementia care unit. One newly employed HCA for the dementia care unit has completed level 3 and is to be enrolled for the dementia unit standards.</p> <p>The manager/RN is interRAI trained. She has also completed competency for syringe driver and male catheterisation.</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</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager/RN is full-time and shares the on-call requirement with the part-time RN.</p> <p>In the rest home, there is one HCA on the full morning shift (7-3 pm) and one HCA on the short shift (7-10 am) Monday to Friday, which is extended in the weekends to 1 pm. A medication competent HCA completes the medication round from 6-7 am. In the afternoons there is one HCA on the full shift (3-11 pm) and one HCA from 4.30 pm-7.30 pm.</p> <p>In the dementia unit, there is one HCA on the full morning shift (7-3 pm) and one HCA on the short shift (7-1 pm).</p>

<p>service providers.</p>		<p>There are two HCAs on the full morning shift in the weekends. There are two HCAs on the afternoon shift with one finishing at 9 pm.</p> <p>There is one HCA in each unit on night shift with another HCA sleeping over in a flat on site.</p> <p>There is a diversional therapist based in the rest home 9 am-4 pm Monday to Friday and an activity coordinator in the dementia care unit 1-4 pm Monday to Friday. The HCAs incorporate activities as part of their role in the dementia care unit.</p> <p>Healthcare assistant's complete laundry duties as part of their duties. There is a designated cleaner on mornings seven days a week. Healthcare assistants stated there is enough time in their shift to complete all cares and laundry duties on their shifts. Residents and relatives interviewed stated there are sufficient staff on duty at all times. There is the flexibility on the roster to increase hours to meet resident acuity.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in locked cupboards in each nurse's station. Archived records are secure in a separate locked area. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant HCA or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry with specific information on the dementia care unit. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term resident admission agreements sighted were signed and dated.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All policies and procedures had been adhered to. There were no standing orders. There were no vaccines stored on site.</p> <p>The facility uses a paper-based and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RNs and senior medication competent HCAs administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication room temperature is checked daily. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication sheets. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service has a chef who works Monday to Friday and a cook who works weekends. Both cooks have completed food hygiene certificates. The chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in the rest home dining room from the adjoining kitchen. Meals for the dementia unit are plated, covered and taken on a trolley to the dementia unit. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. Both cooks do</p>

		<p>a regular 'boil up' for Māori residents. The four-weekly menu cycle is approved by a dietitian. There are ample snacks available in the dementia unit. All residents and family members interviewed were satisfied with the meals.</p> <p>The verified food control plan is due for review on 2 July 2021.</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 service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</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>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were reviewed. Overall, the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition, pain, continence and behaviour.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status and wound care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse, dietitian and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</p>

service delivery.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans reviewed had interventions documented to meet the needs of the resident. At the front of one care plan there was information about epilepsy and an extra sheet outlining clearly first aid in the event of a seizure. Care plans have been updated as residents' needs changed.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>The facility uses short-term care plans for each wound. Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently four minor wounds being treated in the rest home and one in the dementia unit. There are currently no pressure injuries. The facility has pressure injury prevention equipment available.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, neurological observations, wounds and behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a diversional therapist who works 20 hours a week, and an activities assistant who works fifteen hours a week. On the days of audit rest home residents were observed going for walks, playing housie, listening to newspaper readings, participating in exercises and having nail care. Dementia residents were observed going for walks, listening to music and having nail care.</p> <p>There is a monthly programme in large print in each resident's room and on whiteboards in communal areas. The programme in the dementia unit can vary from the printed programme due to residents' mood and fatigue. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is an Anglican church service every Wednesday and Catholic communion on Fridays and Sundays.</p> <p>There are van outings twice a week. One resident has a cat and there are fish tanks in each area. The quality assurance coordinator/administrator often brings her dog in for the day.</p> <p>There are regular entertainers visiting the facility. Special events such as birthdays, Easter, Anzac Day, Matariki and Queens's birthday are recognised and celebrated. The facility had a hangi for Matariki with assistance from the local marae.</p>

		<p>There is community input from pre-schools and schools. Residents go out on a Friday. One week they go to a drop-in café where they play games and have afternoon tea. The next week they go to Age Concern where they have singing and entertainment. Younger residents also go to McDonalds and shopping. They have access to Netflix and the Disney channel, and the facility is also looking at putting in Sky. One younger resident likes to help clearing tables and folding linen in the laundry.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the evaluation of the long-term care plan. Resident meetings are held six-monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All the long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</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>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian, mental health services for older people and the hospice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. There was evidence of one dementia care resident referred for re-assessment for a change in level of care due to decline in mobility. The needs assessor visited on the day of audit.</p>
Standard 1.4.1:	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with</p>

<p>Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</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>The building holds a current warrant of fitness which expires 3 May 2021. There is a maintenance person who works 30-40 hours a week. The maintenance person is also responsible for the gardens. Electrical and plumbing contractors are available when required. The gas contractor checks the gas six-monthly.</p> <p>There is a preventative and reactive maintenance schedule. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home communal lounges, hallways and some bedrooms are carpeted. Other bedrooms have vinyl. The dementia communal lounges, hallways and bedrooms have vinyl. Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large enclosed outdoor area for the dementia unit. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>In the rest home and dementia unit there is one outdoor area where residents smoke. All other areas are smoke free. Smoking in the dementia unit is always supervised. Smoking cessation programmes are offered.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for rest home and dementia level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>All rooms have hand basins. All toilets and showers are communal and there are a sufficient number of these. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are privacy signs on all shower/toilet</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>doors.</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>All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>In both areas there are large and small communal lounges. The larger areas are used for activities and the smaller areas are for residents to read, entertain visitors, play on the computer or just have quiet time. The dining areas are of an adequate size and the use of tablecloths gives a homely feel.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site by the HCAs. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored. There are two sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency, disaster policies and procedures are documented for the service. The service has an approved fire evacuation scheme dated May 2000. Fire drills occur every six months. The orientation programme and two-yearly education/training programme include fire, security and emergency/civil defence situations held last in February 2020. There are adequate supplies available in the event of a civil defence emergency including food (separate store cupboard), water (swimming pool), torches and other civil defence supplies. There is a gas BBQ and gas cooking in the kitchen. There is a generator on site (one for each unit) for emergency power back-up for lights and call bells. A call bell system is in place including all resident rooms and communal areas. Residents were observed in their rooms with their call bell within reach. There is at least one staff member on duty 24 hours a day with a current first aid certificate. The building is secure with surveillance cameras internally and externally. Staff complete internal security checks after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Every bedroom has an electric panel heater. In the rest home the communal areas have gas heaters and in the dementia unit there are heat pumps. Staff and residents interviewed stated that this is effective.</p>

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>The manager/RN has responsibility for coordinating the infection control programme for the facility. Responsibility for infection control is described in the job description. The infection control coordinator is responsible for the collation of infection events in consultation with the quality assurance coordinator. The infection control coordinator provides a report to the staff meeting on monthly infection events. Meeting minutes are emailed to the director/owner. The infection control team (infection control coordinator, quality assurance coordinator and senior HCA) review the infection control programme annually.</p> <p>Visitors are asked not to visit if unwell. The service displays a QR code and there is a declaration register. Staff temperatures are taken daily and residents twice daily using a digital thermometer. Hand sanitisers are appropriately placed throughout the facility. The DHB have been supportive providing regular zoom meetings, additional education, Covid-19 resources and personal protective equipment. The service submitted their pandemic plan to the DHB ensuring preparedness in the event of an outbreak. Influenza vaccines are offered to residents and staff.</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 infection control coordinator has attended infection control and prevention education offered by the DHB and completed an on-line MOH course. She has also been assessed as competent in taking swabs for Covid-19 testing. There is access to infection control expertise within the DHB, aged care consultant, wound nurse specialist, public health, laboratory and GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an aged care consultant and reviewed by the infection control team in July 2020.</p>

<p>reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. There has been additional training around Covid-19. Staff complete annual infection control questionnaires. Hand hygiene competencies are completed during orientation and annually. Resident education occurs as part of providing daily cares. Residents were kept informed daily regarding Covid-19 restrictions and infection control precautions including hand hygiene.</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>	<p>CI</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place that are appropriate to the complexity of service provided. Infection control data is discussed at the monthly staff meeting. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed, and areas for improvement identified. The service has been successful in reducing urinary tract infections.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Infection control internal audits have been completed. There have been no outbreaks.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are current policies that reflect best practice and meet the restraint minimisation standard around restraints and enablers. The manager/RN is the restraint coordinator and has a job description that defines the role and responsibilities. No residents were using enablers on the day of audit. There were two residents with restraints. One rest home resident has bed-sides, and one dementia care resident (awaiting re-assessment) has a safety belt and bed-sides restraint. Restraint is used as a last resort.</p> <p>Care staff interviewed were able to describe the difference between an enabler and a restraint.</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 process is described in the restraint minimisation policy. The restraint team is the RN restraint coordinator, quality assurance coordinator and senior HCA. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Restraint consents had been completed by the RN and EPOA. The GP is involved in restraint authorisation. Restraint use is discussed at the monthly staff meeting. Care staff complete restraint minimisation questionnaires and attend education on behaviours of concern.</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>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RN restraint coordinator in partnership with the GP, resident (as appropriate) and their EPOA. Restraint assessments are based on information, accident/incidents, staff discussion, resident/family discussions and observations. Ongoing consultation with the resident, family/whānau and GP were evident. The two resident files where restraint was in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions trialled before implementing restraint. The use of restraint is linked to the residents' care plan. Risks/interventions associated with the use of restraint are documented in the care plan. Monitoring is documented on a specific restraint monitoring form, evidenced for the two resident files where restraint was being used. The type of restraint used, when required has a time on and time off recorded as well as the restraint checks as per the documented frequency. Written checks include supports/needs provided during the episode of restraint such as position change, food and fluids and toileting. A restraint register is in place providing a record of restraint use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted six-monthly at the same time as the long-term care plan evaluation. A review of the two resident files identified that evaluations were up to date.</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>	<p>FA</p>	<p>Staff meeting minutes record the discussion around restraints. The approval group meet annually to review restraint use. Internal restraint audits measure staff compliance in following restraint procedures. A review of accidents/incidents identified there had been no incidents relating to use of a restraint. The GP reviews restraint use at the residents three monthly review.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	The service has established links with many community organisations. Residents and whānau/family are invited to attend events and functions on site and within the community. Many residents are supported to attend community organisations of their choice. Residents interviewed stated they are happy to be involved in the community and can have visitors of their choice at any time. Relatives interviewed stated they are invited to events and functions held within the facility and	Established community links include visits to the local marae and visiting kaumatua to the service. There are regular visits from the local kohanga childcare centre children who sing and chat with residents. Residents have become pen pals with school children and attend the kapa haka group sessions at the local high school. The kapa haka group also perform at the rest home. There are many Māori community visitors who perform waiata, kapa haka and special performances for kaumātua birthdays and other festivities. Festive occasions and events are celebrated. Matariki was celebrated with a hangi lunch coordinated by the two Māori chefs and prepared involving residents, staff and the marae community. Whānau/family/community groups and staff were invited to join residents for lunch. Residents enjoy outings into the community including fortnightly attendance at the Age Concern entertainment and afternoon tea. Individual residents are supported to attend community organisations such as computer courses and the community Māori Women’s league group and Tangihanga (meetings) at the local Marae. The service has been successful in maintaining community links for residents in their care. This has been confirmed through interviews and reviewing of written compliments and six-week post admission surveys.

		within the community.	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed, and areas for improvement identified. In May 2020 the service identified an increase in urinary tract infections (UTI) and implemented a quality improvement plan to reduce UTIs across both levels of care.</p>	<p>An action plan to reduce UTIs included a focus on standard precautions including hand hygiene and handwashing competencies for all staff; promoting continence management, use of correct incontinent products, regular toileting and resident personal hygiene, encouraging hydration with additional fluids offered including cranberry juice, monitoring residents' fluid intake, offering jellies and ice-blocks in warmer weather. Residents identified as prone to UTIs were reviewed by the GP and use of prophylactic antibiotics considered with Hiprex commenced as prescribed. The manager/RN was assessed as competent to complete male catheterisation changes at the facility for one resident with an indwelling catheter. In June the UTIs had halved with 4 for the month, July 0 and in August there was a spike to 5 UTIs. There was a refresher on infection control practices and hydration rounds discussed at the staff meeting. Staff completed an infection control questionnaire. In September and October there were zero UTIs and there has been one infection in November and one infection in December. There has been no catheter related UTIs. Regular fluid rounds were observed on the days of audit. The service has been successful in reducing UTIs.</p>

End of the report.