

Kapiti Retirement Trust - Sevenoaks Lodge

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kapiti Retirement Trust
Premises audited:	Sevenoaks Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 23 March 2021 End date: 24 March 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:	58

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

Kapiti Retirement Trust provides rest home, dementia and hospital level care for up to 60 residents. The service is operated by a community trust and managed by a chief executive officer, general manager resident wellness, and clinical team managers. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, contracted service providers and a general practitioner. Two new reconfigured, end of life suites were reviewed during audit and both are noted in the report.

Areas for improvement have been identified in relation to the recording of quality improvement data discussed at meetings and sharing this with staff members and having the residents' menu reviewed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Kapiti Retirement Trust. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Kapiti Retirement Trust are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the goals, values and mission statement of the organisation. Monitoring of the services provided to the Board of Trustees was regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained electronically. Staff records are electronic with hard copy files.

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.
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Kapiti Retirement Trust work closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers, communication sheets and electronic vital information reports guide continuity of care.

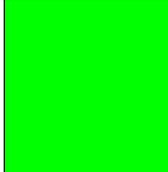
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and family members of residents when interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two diversional therapists and an activities assistant. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by either registered nurses, enrolled nurses or senior care staff, all of whom have been assessed as competent to do so.

Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

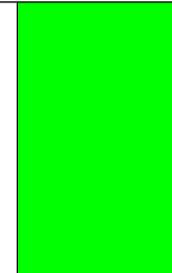
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Eight residents were using enablers at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Nine residents had approved restraints. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisory company or Capital and Coast District Health Board. The programme is reviewed annually.

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, data is analysed, trended, benchmarked 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	48	0	1	1	0	0
Criteria	0	98	0	2	1	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>Kapiti Retirement Trust - Sevenoaks Lodge (Sevenoaks) has procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents' files reviewed in the secure unit evidenced an Enduring Power of Attorney (EPOA) in place that had been activated.</p>

		Staff were observed to gain consent for day-to-day care on an ongoing basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. An exception to this is when the site is complying with and managing the risks associated with Covid-19 alert levels.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families on admission and those interviewed knew how to make a complaint.</p> <p>The complaints register reviewed showed that eight complaints have been received since the beginning of 2020, and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible.</p> <p>The General Manager Resident Wellness (GMRW) is responsible for complaints management and follow up. Staff interviewed confirmed an understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents and family members of residents when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas in English and te</p>

<p>Consumers are informed of their rights.</p>		<p>reo Māori, together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and residents' family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussions with families and the General Practitioner (GP). All residents have a private room.</p> <p>All personnel entering Sevenoaks are advised that CCTV surveillance is operating throughout the facility.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents and 15 staff at Sevenoaks at the time of audit who identified as Māori. Interviews verify staff would be able to support residents who identify as Māori to integrate their cultural values and beliefs if required. There is a current Māori health plan developed with input from cultural advisers that enables the principles of the Treaty of Waitangi to be incorporated into day-to-day practice, including the importance of whānau to Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	<p>FA</p>	<p>Residents and residents' family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members of residents when interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with, and sign an agreement which includes House Rules as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>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, older persons mental health team, physiotherapist, district nurses, services for older people, psycho-geriatrician, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education seminars. The wound care nurse at Sevenoaks is a member of the wound care society and attends wound care forums. Evidence is sighted of complex wounds healing with the management strategies put in place by the facility's trained wound care nurse. Continuity of care at Sevenoaks is enhanced by at least one senior healthcare assistant being on duty in the hospital wing each shift. The senior healthcare assistant works in the same wing whenever they are on a shift and is a key contact for care staff. All residents at Sevenoaks have a key worker, who is an RN that is allocated to planning that resident's care and is a point of contact for the resident and the family.</p> <p>Other examples of good practice observed during the audit included: The prompt attention to the updating of care plans and implementation of short-term care plans following the GP visit; the commitment to ensuring residents are kept safe during Covid responses and the continued potential risk of exposure to Covid-19 with all persons entering the site required to sign in or scan, complete a health questionnaire, are temperature checked, and are required to use hand sanitiser.</p> <p>In addition, Sevenoaks is committed to ensuring an individualised approach to residents' care is provided,</p>

		as evidenced by documentation, observation and interviews.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Throughout the period when visitors were unable to visit, residents were enabled to communicate with families via phone or electronic means. A weekly newsletter was sent out by management to keep all residents and their families informed of the recent Ministry of Health updates regarding Covid-19, and the impact of those requirements on the operations at Sevenoaks. A key member of the management team was onsite every day during this time.</p> <p>Interpreter services can be accessed via an external interpreter service, accessed through the Department of Internal Affairs or Capital and Coast District Health Board (CCDHB) when required. Staff knew how to access these services.</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>The Trust's strategic plan is reviewed annually by the management team. The plan outlines the purpose, values, mission, scope, direction and goals of the organisation. The document describes five year objectives with associated operational plans. A sample of quarterly reports to the board of directors showed that adequate information is reported to monitor performance, including financial performance, emerging risks and issues, staff education and any significant issues relating to residents and care.</p> <p>The service is managed by a CEO who holds relevant qualification in management and has been in the role for 12 years. The CEO is supported by two general managers; the general manager resident wellness (GMRW) and the general manager support services (GMSS). Responsibilities and accountabilities for each of these three roles are defined in job descriptions and individual employment agreements. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through regular attendance at sector-based workshops, reading, membership of the New Zealand Aged Care Association (NZACA) and the Retirement Villages Association. (The Trust runs a large village which is co-located on the same site but is not part of this audit.)</p> <p>The GMRW is a registered nurse who maintains her practising certificate and has an MBA (achieved in 2014). She has worked in the aged care sector as a nurse and as a manager at the Ministry of Health (MOH), moving to the Trust in 2017.</p> <p>The service holds contracts with the Capital & Coast District Health Board (C&CDHB) for long term</p>

		<p>chronic health conditions (LTCH), older adults (ARRC), palliative care, a contract for five respite beds for the Wellington region, and a contract for people under 65 with MOH.</p> <p>On the day of audit, 57 residents were occupying beds. Thirty-five residents were receiving hospital level care, eleven residents were receiving dementia care and eight residents were receiving respite care services. One of the respite care residents was receiving palliative care on the first day of the audit. (One additional resident was receiving respite care on a private basis. They are not included in the 57 residents.)</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>When the CEO is absent, the GMRW carries out all the required duties under delegated authority.</p> <p>There are two clinical managers. In longer absences of either one, an experienced registered nurse (RN) is appointed to take responsibility for any clinical issues that may arise. At the time of the audit this arrangement was in place. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Moderate	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, an annual resident satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, use of restraints and enablers, pressure injuries and medication errors. There is bench-marking with an external provider which provides comparison with similar aged care facilities.</p> <p>There are regular monthly meetings occurring. This includes the registered and enrolled (RN/EN) meeting and the Quality Committee meeting. A standard agenda is used for both and includes the opportunity to record data from quality indicators. The meetings have been held each month as scheduled with required staff members attending.</p> <p>The Quality committee is made up of staff members who have responsibilities for infection control, fall reduction, pressure injury prevention, wound management, restraint and enabler use, continence and medication.</p> <p>There were approximately bi-monthly reports presented from the infection control coordinator and approximately quarterly reports on falls data. However, very little, and often no data, is recorded in the minutes and few reports had been received from each of the other staff with responsible for other areas.</p> <p>There is a limited record of discussions at the meetings and no record of any analysis and evaluation of</p>

		<p>what the data which is provided means. When interviewed, the clinical team managers (CTMs) and GMRW state that the data is presented and discussed, but no record has been made for the past year. They agreed that there has been little or no analysis and/or evaluation of the data overall. Areas for improvement have been identified in relation to these two criteria.</p> <p>Staff reported their involvement in quality and risk management activities through the reporting of events, hazards and receiving feedback about events they report. They are able to report incidents easily and track these through the resident management system quickly.</p> <p>The quality improvement records include detailed notes of corrective actions being developed and implemented to address shortfalls and to assist the facility in responding to issues they have identified. A significant example since late 2019 has been their implementation of the new electronic resident management system. A number of individual quality improvements have been used to address different aspects of this rollout.</p> <p>Resident and family meetings are held twice a year. The exception to this was the March/April 2020 meeting which coincided with the Alert Level 4 lockdown and was cancelled. To replace this, Kapiti Retirement Trust sent weekly newsletters to families, keeping them informed of what was happening in the facility. Minutes of the meeting completed in March 2021 were reviewed and confirmed involvement, sharing of relevant information and the opportunity for questions. Resident and family satisfaction surveys are completed annually. The most recent survey showed that overall satisfaction and wellbeing continues to be high at 94% and 91.2% over 2019 and 2020 respectively.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GMRW and the chair of the Health and Safety Committee described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both are familiar with the Health and Safety at Work Act (2015) and the requirements of the act are implemented. A review of the hazard register and hazard reporting system confirmed that this is an effective one. The clinical managers confirmed that the hazard reporting system provides a safe environment for residents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. This is now completed in the resident management system. 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.</p> <p>As noted, while event data has been collated and discussed at both the Quality Committee and the RN/EN</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>monthly meetings, there has been a lack of overall analysis and evaluation recorded and reported to the wider staff group. (Refer criteria 1.2.3.5 and 1.2.3.6)</p> <p>The GMRW described essential notification reporting requirements, including for pressure injuries and changes in the Board of Trustees. There have been 11 section 31 notifications to the MOH since the previous audit. These involved an injury to a resident in 2018, a pressure injury in 2019 and two pressure injuries (acquired at the Trust) in 2020. An investigation by the Trust in 2019 into two missing fentanyl patches included them reporting this to the local Police. However, the Police did not undertake their own investigation. All notifications have been acknowledged by HealthCert team members.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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 qualifications and practising certificates (APCs), where required. A sample of 11 staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and performance monitoring after their first two months in their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. A comprehensive training programme was seen.</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. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are nine HCAs in the dementia unit and six have the completed the dementia unit standards and either Level 3 or Level 4 Health and Wellbeing. A further three new staff members have been at Kapiti Retirement Trust for less than a year with one of these staff members completing the Level 2 qualification and the remaining two staff members yet to be enrolled in a qualification.</p> <p>There are eight trained and competent registered nurses who are maintaining their annual interRAI competency requirements and this is sufficient to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>A range of seven staff members were interviewed during the audit. They were satisfied with the availability of training and support from their manager or supervisor. The resident satisfaction survey results for Care and Service delivery in 2019 and 2020 were 93.4% and 90.7% respectively.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. Every effort is made to replace staff in any unplanned absence. Where this is not possible a safe process for allocation of available HCAs was noted in the rostering system. Most staff members on duty have current first aid certificates, with only new staff members waiting to complete theirs. There is 24 hours a day, seven days a week (24/7) RN coverage in the hospital.</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 resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' electronic files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic records are stored in a secure portal.</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>Residents are admitted to Sevenoaks following an assessment by the local Needs Assessment and Service Coordination (NASC) Service, that confirms the resident requires the services provided by the facility. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the GMRW. They are also provided with written information about the service and the admission process.</p> <p>Residents requiring admission to the secure unit do have an EPOA in place that has been activated, and an authorisation by a Specialist that placement of the resident in a secure unit is necessary.</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</p>

		detail, assessments, and signed admission agreements in accordance with contractual requirements.
<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>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Capital and Coast District Health Board (CCDHB) 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There was one resident at Sevenoaks who self-administers medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors are reported to the RN and the Clinical Team Leader (CTL) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p>

		Standing orders are used at Sevenoaks and meet standing order guidelines.
<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>	PA Low	<p>The food service at Sevenoaks is overseen by a Food Services Manager and the food service is provided on site by a cook. The menu was unable to be verified as being in line with recognised nutritional guidelines for older people, as it has not been reviewed by a qualified dietician since 27 July 2017. This is an area identified as requiring attention.</p> <p>An up-to-date food control plan is in place. The verification audit took place on 19 February 2020, by the Kapiti District Council and expires 19 August 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken safe food handling training 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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit have access to food any time of the day or night.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</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>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC (or the social worker assisting the resident) is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. 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. Examples of this occurring were discussed with the GMRW. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Sevenoaks are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. Wound care assessments include photographic data.</p> <p>Files reviewed of residents in the secure unit, included a behaviour assessment.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at Sevenoaks are electronic and those reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly recorded, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Files reviewed of residents in the secure unit contained a behaviour management plan, that included identified triggers. Monitoring of any events of behaviours that were challenging was sighted and this documentation was used to assist in evaluating the effectiveness of the management strategies being used.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified the provision of care to residents was consistent with their needs, goals, and the plan of care. Wound and behaviour management plans were comprehensive and included evidence of effectiveness in the management strategies. Evidence was sighted of an individualised approach to the care being provided to each resident. The attention to meeting a diverse</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>range of resident's individualised needs, was evident in all areas of service provision.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. Sevenoaks has installed twelve ceiling hoists for transferring immobile residents. A further twelve will be installed later this year.</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 at Sevenoaks and is run by the Lifestyle and Leisure Team which includes two qualified diversional therapists, two recreation coordinators and the assistance of up to 60 volunteers. The programme is provided Monday to Saturday. Activities are no longer provided on a Sunday, at the request of families and residents, however a movie is played every Sunday at 2.30pm.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, cultural, religious, spiritual, and social requirements. A 'life map' portrait is created for each resident, and visually portrays the resident's values and beliefs, memorable holidays, employment/skills, childhood memories, parents, siblings and other aspects of the resident's life. This enables staff to have some knowledge of the resident's life prior to living at Sevenoaks. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the three-monthly and six-monthly care plan review.</p> <p>The activities plan has recently been revamped and includes the diversional therapist being present in the dementia unit six days a week, offering a programme specific to these residents. The activities assessment of each resident in the secure unit, identifies a twenty-four-hour approach that includes all aspects of the resident's life and past routines. The programme includes van outings, walking bus, sing a long, sit dance exercises, cooking, bowls, crafts, canine friends, nail care and church services. On the first day of audit the residents in the unit were observed assisting in preparing and cooking their morning tea. Family members were also active participants.</p> <p>A different programme is offered for the other residents and includes exercises daily, mystery activities, cooking, men's group, bingo, skittles, news, crafts, and van outings. This programme now focusses more on residents 'doing' rather than watching. Increased participation and improved dexterity of residents has been noted, though no formal evidence has been documented. Hospital residents unable to attend, have one on one sessions provided. The planned monthly activities programmes sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is displayed in all common areas and in each resident's room. A facility</p>

		<p>van and a bus enable residents to attend a range of outings and community events. Sevenoaks recently acquired a soft sand wide-wheel wheelchair, that allows the Lifestyle and Leisure Team to take residents to the beach. The chair can go in the water for residents to feel the water on their toes or can be used for walks on the beach.</p> <p>Residents and family meetings are twice a year. Meeting minutes, satisfaction surveys and interviews verify a high degree of satisfaction with the activities provided at Sevenoaks.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care at Sevenoaks is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN, and passed over to oncoming staff at handover.</p> <p>Formal care plan evaluations occur every three months following the GP review and every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans are consistently reviewed for infections, pain, weight loss, medication changes or changes in medical instructions, and progress evaluated. Wound management plans were evaluated each time the dressing was changed and included photos to evidence changes.</p> <p>Residents in the secure unit had ongoing evaluation of the effectiveness of behavioural management strategies and monitoring of any medication changes regarding not only its effect on behaviour, but identifying any potential increased risks associated with certain medications. Evidence verified staff in the secure unit were alert to changes in residents' status, that could be indicative of a potential problem when the resident was unable to verbalise.</p> <p>Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals, cleaning products and cleaning services. They also provide relevant training for 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. There is provision and availability of protective clothing and equipment and all staff (contracted and employed) were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 11 November 2021) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility for visitors and staff. These are in addition to facilities for residents.</p> <p>Each wing has 12 bedrooms except for one wing, which has 13. Every wing has two bathrooms with a toilet and an additional 1 separate toilet. The Matai (respite) wing has 11 bedrooms, of which, two are the palliative care suites, one of which is new. These each have their own ensuite bathrooms.</p> <p>Appropriately secured and approved handrails are provided in all of the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely.</p> <p>All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff reported satisfaction with residents' rooms, particularly those which have had already had ceiling hoists installed. Residents also reported the adequacy of bedrooms. The 2020 resident satisfaction survey results for personal rooms was 85%. Slightly lower than 90% in 2019.</p> <p>The palliative care suites in the Matai wing differ slightly. One of the rooms has a couch which can be folded out to accommodate family/whanau sleeping overnight. The other has a large, comfortable armchair, which can recline. They are both decorated in a homely and comfortable way, and can be personalised when occupied. The two suites have adequate room for additional visitors, safely manoeuvring the resident on the bed or mobility equipment.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>The two palliative care suites both have access to their own private garden area directly off the suite. There is external seating available. The GMRW discussed their desire to survey families who have utilised the palliative care suites. The Quality Committee are still working on a way to do this respectfully and compassionately.</p> <p>Resident satisfaction survey results for the general accommodation areas were 89.7% in 2019 and 90.2% in 2020.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry for personal items and /off site by a contracted provider for bed linen. Family members occasionally take special items home for delicate laundering if requested.</p> <p>Dedicated laundry/housekeeping staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The 2020 resident satisfaction survey results for cleaning and laundry services was 91%.</p>

		<p>As noted in standard 1.4.1 the cleaning team are provided by an externally contracted service. Chemicals were stored in a secure cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through staff monitoring and the internal audit programme. These confirmed that the cleaning and laundry services is performing well. During interview with a group of housekeeping/laundry staff they reported the ability to provide feedback on the adequacy of the external laundry service and the cleaning products. They were satisfied with this process and had been able to make changes when needed.</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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were 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 current fire evacuation plan was approved by the New Zealand Fire Service in 2009. A trial evacuation takes place six-monthly. The most recent being on 4th December 2020. There is also a six monthly Emergency Shutdown Tour which includes how all the water, gas and power systems are shutdown if this is needed during an emergency. This is run by the manager of the maintenance team who is a fire warden. When scheduled, the 'tour' is run at three different times so that as many staff members can attend as is possible. Review of 11 personnel files confirmed that all staff had attended at least one tour and fire drill in the last 12 months.</p> <p>The reconfiguration of the two new end of life suites have not required any change to the fire evacuation plan. This was confirmed with the fire service during construction.</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 BBQs were sighted and meet The National Emergency Management Agency recommendations for the region. Water storage tanks are located around the complex and provide 30,000 litres of water. There is a generator on site. Emergency lighting is regularly tested when the generator is tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the entire premises at night.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately.</p> <p>Heating is provided by gas-fired hot water, which feeds underfloor heating throughout the facility. Rooms have natural light, opening external windows and some rooms have doors that open onto outside garden or small patio areas.</p> <p>Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from an external advisory company, the infection control team at the CCDHB and the infection control committee. The infection control programme is reviewed annually.</p> <p>A senior Healthcare Assistant (HCA) with input from the RN is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. There is an infection control committee at Sevenoaks that meets every three months to discuss any infection related concerns. The committee includes the infection control coordinator, CTM, kitchen manager, GMRW, RN, HCA, a cleaner and a representative from the village wellness team. The committee assists the infection control coordinator in managing any outbreaks or any IC events at Sevenoaks. Infection control matters, including surveillance results, are reported monthly to the GMRW, and tabled at the quality/risk meeting, RN meeting and the board meeting. Infection control statistics are entered into the organisations database and the database of an Australasian benchmarking organisation. The results are benchmarked with other Australasian facilities, in addition to being used internally to benchmark against previous infection data from Sevenoaks.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. Signage also outlines the restrictions on entering the facility while at each alert level for the management of Covid-19. 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 related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	<p>FA</p>	<p>The infection control coordinator has appropriate skills, knowledge, and qualifications for the role. The infection control coordinator has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the CCDHB are available and expert advice from an external advisory company</p>

<p>physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>is available if needed. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection control coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the infection control coordinator. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in eye infections and an influenza-like-illness outbreak in 2020.</p> <p>Training on how to use personal protective equipment properly is ongoing to ensure staff are trained to manage the risk of exposure to Covid-19.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>

<p>Standard 3.5: Surveillance</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>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record and a short-term care plan is commenced. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control coordinator and GMRW review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are not shared with staff via quality and staff meetings (refer criterion 1.2.3.5). Surveillance data is entered in the organisation's electronic infection database. Records identify trends for the current year, and comparisons against previous years. Data is benchmarked externally with other Australasian aged care provider. Results evidence a low rate of infections at Sevenoaks.</p> <p>An outbreak of influenza resulted in the quarantining of Sevenoaks for two weeks in late in 2020. All residents presenting with symptoms were tested for Covid-19, at that time.</p> <p>A good supply of personal protective equipment is available. Sevenoaks has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.</p> <p>The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, nine residents were using restraints and eight residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff involved.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for</p>	<p>FA</p>	<p>The restraint approval group is made up of the GMRW, an administration team member, an RN who is the quality committee representative and an experienced registered nurse who has been restraint coordinator for 18 months. They are responsible for the approval of the use of restraints, maintaining the restraint and enabler register and the restraint processes. It was evident from review of meeting minutes, residents' files</p>

<p>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>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 and analysed.</p> <p>Evidence of family, whānau and EPOA involvement in the decision making was on file for each restraint. 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 undertakes the initial assessment with consent from the resident's family/whānau/EPOA. The general practitioner is involved in the 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.</p> <p>The restraint coordinator was interviewed and described the documented process. The desired outcome is to ensure the resident's safety and security and to minimise the use of restraint wherever possible.</p> <p>Completed assessments were sighted in 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 (eg, the use of sensor mats, low beds and alternative activities).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each annual restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and, although not recorded in the</p>

<p>Services evaluate all episodes of restraint.</p>		<p>minutes (refer Standard 1.2.3) are discussed at monthly RN/EN meetings and Quality Committee meetings. Residents' files confirm involvement of families in the evaluation and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Annual restraint meetings are held, and individual use of restraint use is reported to the quality and RN/EN meetings. (Although as noted, this has not occurred during 2020, it is in the restraint policy).</p> <p>Minutes of the most recent restraint approval group meeting – March 2021 - confirmed analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>Any changes to policies, guidelines, education and processes are implemented if indicated. An annual internal audit also informs these meetings. Data reviewed, minutes and interviews with the GMRW and restraint coordinator confirmed that the use of one type of restraint reduced from two to one during 2020.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	There are regular monthly meetings of the Quality Committee and the RN/ENs and a standard agenda / minutes template is used. Minutes of these monthly meetings are maintained. Staff who attend both meetings report that quality improvement data from key components of service delivery are discussed during every meeting.	When reviewing the minutes from each meeting they are not recording all the details which are being discussed at the meeting and a complete record of all quality improvement data is not being retained.	<p>Ensure that those staff members who are required to report on quality improvement data provide the data on the report template, and the minutes record the discussion of the data.</p> <p>60 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers</p>	PA Moderate	There are regular monthly meetings of the Quality Committee and the RNs/ENs which have a standard agenda. The agendas include the opportunity to share and discuss quality improvement from the previous month and comparison of that data. The facility benchmarks their data with an external agency which provides comparison across the aged care	<p>Although the meetings have been regular, the minutes do not record any analysis and evaluation of what the data.</p> <p>When interviewed, the three clinical managers and the GMRW agreed that, during</p>	<p>Ensure that the analysis and evaluation quality improvement data occurs during the Quality Committee meeting and the RN/EN meeting as appropriate.</p>

<p>and, where appropriate, consumers.</p>		<p>sector.</p> <p>Staff members and managers who attend confirm that the meetings occur and that there is discussion of data and benchmarking on a monthly basis.</p>	<p>2020 and until the audit, there has been little or no analysis and/or evaluation of the data overall.</p> <p>Staff who were interviewed reported their involvement in quality and risk management activities through the reporting of events, hazards and receiving feedback about events they report.</p> <p>However, those staff members who don't attend these meetings reported that they have not consistently received collated, evaluated quality improvement data.</p>	<p>60 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>The food service at Sevenoaks is overseen by a Food Services Manager and the food service is provided on site by a cook. The menu was unable to be verified as being in line with recognised nutritional guidelines for older people, as has not been reviewed by a qualified dietician since 27 July 2017.</p> <p>An email was sighted that verifies an appointment for the dietitian to visit the site has been confirmed for early May 2021.</p>	<p>The menu at Sevenoaks has not been verified within the past two years as meeting the nutritional guidelines/needs of older people.</p>	<p>Provide evidence the menu at Sevenoaks meets the nutritional guidelines for the needs of older adults.</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.