

Leighton House Limited

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: Leighton House Limited

Premises audited: Leighton House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 11 May 2021 End date: 12 May 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: 47

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

Leighton House is operated by Dementia Care New Zealand (DCNZ). The service provides care for up to 50 residents requiring rest home or hospital (medical and geriatric) level care. On the day of the audit, there were 47 residents.

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

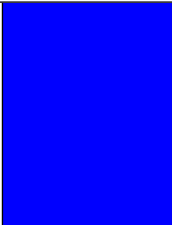
The service is managed by an operations manager and a clinical manager (registered nurse). The on-site team is supported by DCNZ management team including a national clinical manager and the managing director who supported the service during the audit and the quality system manager and education coordinator.

Residents, relatives, and the nurse practitioner (NP) interviewed spoke positively about the service provided.

Shortfalls identified during the audit related to the quality programme, completion of neurological observations following an unwitnessed fall, documentation of interventions and involvement of family in care planning, and to documentation of allergy status.

Two ratings of continuous improvement have been given to the cultural support provided to Māori residents and to the surveillance of infections.

Consumer rights

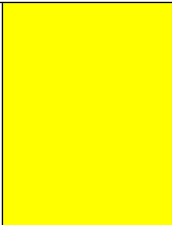
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, with complaints responded to in a timely manner.

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 low risk.
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Dementia Care New Zealand provides oversight and support to the service. Services are planned to meet the needs of the residents. Goals are documented for the service with evidence of regular reviews. There is a documented quality and risk management programme. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, seven days a week.

The resident files are appropriate to the service type.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a welcome package and information available before or on entry to the service. Registered nurses are responsible for all stages of provision of care including assessments, care plans and evaluation of care. Care plans are based on the interRAI outcomes and other assessments. Residents and family interviewed confirmed they were involved in the care planning and review process.

The activity team involve residents and volunteers in the implementation of the integrated activity programme. The programme is varied and interesting and meets the abilities of residents.

Staff who administer medications have had education around medication management and completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents interviewed were complimentary about the food service.

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 building has a current warrant of fitness. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times.

All rooms are single and personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are well utilised for group and individual activity. The dining room and lounge seating placement encourages social interaction. Other outdoor areas and decks are safe and accessible for the residents.

There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely. Home assistants carry out laundry and cleaning duties and maintain a tidy and clean environment.


Policies and procedures to manage an emergency were able to be described by staff. Equipment is stored on site to be used in the event of an emergency.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation and management of challenging behaviour. One restraint and no enablers were in use during the audit.

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.
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The infection control programme is appropriate for the size and complexity of the service. The infection control nurse (registered nurse) is responsible for coordinating the infection control programme and providing education and training for staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities. Two outbreaks have been well managed.

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	44	0	2	2	0	0
Criteria	2	93	0	4	2	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) policy and procedure is implemented. Discussions with staff (six caregivers, two registered nurses (RN), two activities coordinators, one maintenance staff, two home assistants, one cook, one operations manager and one clinical manager) confirmed their familiarity with the Code. Interviews with 13 residents (10 rest home and three hospital), and five families (three rest home and two hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff, and quality meetings.</p> <p>Code of Rights training including advocacy, informed consent, privacy and prevention of neglect and abuse, are part of the mandatory training days that staff undertake which are facilitated each year to ensure all staff attend.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>The service has policies and procedures relating to informed consent, resuscitation, and advanced directives. All resident files reviewed (three hospital and four rest home) included signed informed consent forms (including photograph for identification and marketing) and resuscitation status appropriately signed. Advanced directive instructions where available were on the resident file. Care staff could describe the informed consent process as it related to delivering cares.</p>

provided with the information they need to make informed choices and give informed consent.		Admission agreements were sighted which were signed by the resident or nominated representative. The admission agreement also includes permissions granted. Discussion with residents and families identified that the service actively involves them in decision making.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information about the National Health and Disability Advocacy Service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. Each complainant is offered advocacy services as part of the response/acknowledgement of the complaint.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that visit the facility. Resident meetings are held monthly. The service has maintained communication with family during the Covid-19 pandemic that included keeping the family informed about their relative and activities held at the service.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Interview with residents and relatives confirmed an understanding of the complaints process. There is an up-to-date complaint register. There have been two complaints in 2020 and two in 2021 to date. All four complaints reviewed included a letter to the complainant acknowledging the complaint, investigation and follow up with the complainant to explain the result of the investigation. All responses occurred in a timely manner as per the Code and policies. Management operate an open-door policy and all residents and family stated that they would inform the manager/s of any concerns and all felt that their concerns would be addressed. Issues raised through complaints are addressed individually, however the themes, recommendations and improvements do not link to the quality programme (link 1.2.3.5).
Standard 1.1.2: Consumer	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the operations manager or clinical manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p> <p>Managers and staff interviewed as part of the audit confirmed their understanding of the Code and they were able to describe how they informed family and residents of this on a regular basis.</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>	FA	<p>Residents are treated with dignity and respect. Discussions with residents and relatives are positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans.</p> <p>The service has policies which align with the requirements of the Privacy Act 2020. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs are met. Privacy is ensured, and independence is encouraged.</p> <p>There is a policy that describes spiritual care. Church services are conducted weekly. All residents interviewed indicated that their spiritual needs are being met.</p> <p>There is a policy around identification of and management of abuse and/or neglect. Staff have received training annually around this and when interviewed, were able to describe what to look for and that they need to report and how to manage any incident. A review of incident forms for 2021 did not identify any incidents of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	CI	<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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident.</p> <p>There were four residents who identified as Māori living at the facility. Two records were reviewed for residents who identify as Māori. All had cultural needs identified as part of the assessment and the care plan identified specific activities and support required.</p> <p>There are links to the local marae. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. There are 50% of staff that identify as Māori including the operations manager who provides leadership for the service. Staff identify with different iwi including Ngāti Porou. Staff receive education on cultural awareness during their induction to the service and as a regular</p>

		<p>in-service topic. All care staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>The activities programme includes activities that reflect Māori. Guests to the service include a kapa haka/performer and teacher of traditional Māori dance, a teacher and carver/ kaumātua who carves and displays art work with teachings around tikanga, purakau and stories of Tairāwhiti, and a raranga/weaver and tutor of Māori medicine.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's spiritual and cultural needs.</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>The managers and RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respect them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistant role and responsibilities.</p> <p>Professional boundaries are reconfirmed through education and training sessions, and staff meetings and performance management if there is an issue with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security, and self-esteem. Interviews with care staff confirmed that they understood how to build a supportive relationship with each resident.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. There are a number of GPs caring for the residents at Leighton house. Each resident identifies which general practitioner (GP) they choose to have visit and the nurse practitioner visits the facility on a twice weekly basis. Some GPs provide an after-hours service and an after-hours' service is provided at the local public hospital for others. The GP or nurse practitioner reviews residents identified as stable every three months, with more frequent visits for those residents whose</p>

		<p>condition is not deemed stable. The nurse practitioner interviewed was satisfied with the level of care that is being provided.</p> <p>The service receives support from the district health board, which includes nurse specialists' visits. A physiotherapist is contracted to be on site for 1.5 - 2 hours per week. A dietitian is available for consultations. There is a regular in-service education and training programme for staff. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent. Leighton House is benchmarked against other DCNZ facilities.</p> <p>DCNZ management team provide oversight and support for clinical aspects of care, operational management and for education. DCNZ Management team including the national clinical manager, quality systems manager, education coordinator and managing director visit the site regularly.</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>Relatives interviewed stated they were welcomed on entry and given time and explanation about the levels of care provided and services and procedures. There is documented evidence of full and frank open disclosure regarding changes to their relative's health including incident/accidents, medication changes, GP visits and infections. Relatives interviewed confirmed that they are notified of any changes in their family member's health status. Resident meetings are held monthly, and family are able to attend. There are no residents requiring access to an interpreter, however the manager was able to describe how they could be accessed if required.</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>Dementia Care New Zealand (DCNZ) is the parent company for Leighton House with nine sites in total. The DCNZ team includes senior managers and others who provide support both on site and in real time via phone. The service provides care for up to 50 residents requiring hospital, (medical and geriatric) and rest home level care. There are 25 dual-purpose beds. On the day of the audit there were 47 residents (13 at hospital level care and 34 at rest home level care). There were no residents under the medical component. All residents were under the aged care contract.</p> <p>There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. DCNZ has an organisational 2020-2021 business/strategic plan. The business plan is regularly reviewed with the operations manager confirming that they are also involved. .</p> <p>The clinical manager (RN) has been in the role for two years and is supported by and reports to the national clinical manager who was present to support the clinical manager on the day of audit. The clinical manager has 15 years' experience in aged care and has held past roles in education and quality management with previous experience as clinical manager in district nursing services.</p>

		The operations manager (non-clinical) of Leighton House has been in the role since August 2013. The operations manager reports to the operational management leader at DCNZ. The operational manager is supported by an organisational quality systems manager, education coordinator, and owners/directors. The operations manager and clinical manager have attended at least eight hours of professional development in the past year.
<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	During the temporary absence of the operations manager, the clinical manager covers the operations manager's role. The national clinical manager provides oversight to the senior registered nurse appointed to cover for the clinical manager if they are on leave.
<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 Low	<p>There is a quality plan that includes quality goals and risk management plans for Leighton House. The quality programme is managed by the operations manager and clinical manager. A quality systems manager for the organisation oversees the quality programme ensuring the programme is implemented.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed at the DCNZ office with input from managers at the sites. Policies and procedures have been updated to include reference to the reviewed Privacy Act 2020. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are expected to sign that they have read the new/revised policies.</p> <p>Data is collected in relation to a variety of quality activities. Clinical indicators are reviewed including a review of incidents and accidents. The complaints programme is not integrated into the quality programme currently. An internal audit schedule has been documented with audits completed in 2021. The operations manager completes environmental and non-clinical audits. The clinical manager undertakes all clinical audits. The operational audits have been completed in a timely manner with corrective action plans documented and evidence of resolution of issues in a timely manner. Clinical audits, while completed, do not have corrective action plans documented in a timely manner.</p> <p>Interviews with staff confirmed that there is discussion about quality data at various facility meetings including monthly health and safety meetings, resident/family meetings, infection control meetings, quality</p>

		<p>meetings and clinical meetings. Staff meetings are also held and there are clinical and operational bulletins put out monthly that include analysis of data and a full report on clinical and operational status of the service. There is documented evidence in meeting minutes of quality data, trends, and analysis apart from complaints which is not linked to the quality programme. Minutes and the staff monthly bulletin (displayed on the staff noticeboard) contain topical information and quality data. Organisational policies meet all current requirements and are reviewed at DCNZ office.</p> <p>Annual surveys are completed with the April 2021 survey showing a high level of overall satisfaction from residents and family. Of the 30 respondents, 85% stated that they would recommend the service. Results would be discussed at the next resident meetings. Results of the 2020 surveys were discussed at the resident meetings and the results of the 2021 survey are on the agenda for the meeting in May 2021.</p> <p>The service has a health and safety committee which meet monthly. The two health and safety representatives interviewed were able to describe their role. All committee members and staff have completed health and safety education annually. Health and safety objectives for 2021 are known by staff. Hazards are documented and resolved in a timely manner.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Equipment is provided including hip protectors, sensor mats, high-low beds, fall out mattresses, bed loops to assist mobility, and residents are encouraged to attend exercises programmes. RNs focus on managing pain and care staff ensure that the call bell is within reach with this was observed to be in place during the audit. There is a multidisciplinary meeting when required for residents identified as having frequent falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. An online incident/accident register is maintained. The clinical manager investigates clinical incidents, accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence.</p> <p>During audit, 29 incident forms were reviewed. Of these, 22 were for residents who had an unwitnessed fall with 12 showing that neurological observations were completed as per policy (link 1.3.6.1). All incident forms reviewed demonstrated that an investigation had occurred following an incident.</p> <p>Discussions with the operation's manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and were able to provide examples.</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>There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Current practising certificates were sighted. Seven staff files were reviewed (one clinical manager, one operations manager, two registered nurses, one healthcare assistant, one activities coordinator and one cook) and there was evidence that reference checks and police vetting were completed before employment for those employed after ownership by Dementia Care NZ.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme. The in-service education programme for 2020 was mostly completed noting that the pandemic stopped some sessions, but introduced others related to managing in the Covid-19 environment, and 2021 training has been completed as per schedule. There is good attendance at training. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months.</p> <p>The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB when these are offered. Of the 19 caregivers employed, there are seven staff who have completed level 4 Careerforce, nine that have completed level 3 (plus one in training), and one that has completed level 2. There are 16 staff who have completed first aid training. The organisation has an education coordinator who provides support and advice. There is a clinical manager and one registered nurse who have completed interRAI training. The service is working to get another trained.</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>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Leighton House roster identifies there is sufficient staffing cover for the safe provision of care for rest home and hospital residents.</p> <p>The building is single storey with staff rostered over the wings. Wings include the administration wing (nine beds with nine occupied including two rest home and seven hospital); east wing (11 beds with nine occupied including five rest home and four hospital); garden wing (11 beds with 10 occupied – all rest home); river wing - eight beds with eight occupied – all rest home; north wing (11 beds with 11 occupied – nine rest home and two hospital). Hospital residents are clustered together to ensure sufficient staff are on each shift and administration wing is nearest the nurses' station with the greatest number and highest acuity of hospital residents.</p> <p>Staff are rostered as follows: six caregivers morning shift (three long and three short from 7 am to 12.30 pm); six caregivers in the afternoon shift with three long and three short shift (5 pm to 9 pm); two caregivers overnight. There is a home assistant rostered on each shift including nights who do household work (e.g.: laundry and cleaning, but not care work). There is 24/7 registered nurse cover.</p> <p>Staff are visible, available and attend to call bells in a timely manner as confirmed by all residents and</p>

		relatives interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and relatives interviewed reported there are sufficient staff numbers.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	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 the resident's individual record. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrated service integration with only medication charts held on the electronic medication management programme.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager screens all potential residents prior to entry. Residents and relatives interviewed confirmed they had the opportunity to discuss the admission agreement with the operations manager. The admission agreement form in use aligns with the requirements of the Age-Related Care contract.
<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	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures transfer of information occurs. Relatives are notified prior to a transfer occurring.
<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</p>	PA Moderate	The medication management policies and procedures comply with medication legislation and guidelines. All medicines were stored safely in the main medication room. Registered nurses and senior care givers complete medication competencies (including oxygen therapy and insulin administration) to administer medicines and competency is renewed annually. Only the RNs administer 'as required' medications. Registered nurses complete syringe driver competency. There were no residents self-medicating on the day of audit.

<p>safe practice guidelines.</p>		<p>The facility uses a robotically packed medication management system for the packaging of all tablets. The registered nurse on duty reconciles the delivery and documents this on the first 24 hours of medication sachets. The electronic medication identifies the pack has been checked in. There is impress stock of medications including antibiotics which are checked regularly for stock levels and expiry dates. The medication fridge is monitored with daily records within the acceptable range. There is an extractor fan in the medication room with daily records below 25 degrees Celsius. Eyedrops in use are dated on opening in the two trolleys.</p> <p>Electronic medication charting is utilised for prescribing and administering medications. Fourteen medication charts were reviewed, and all had photograph identification, however not all medication charts had an allergy status documented. There is evidence of three-monthly medication reviews by the GP. 'As required' medications had indications for use with the effectiveness documented in progress notes.</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>All food is cooked on site and delivered in (hot boxes) to the two smaller homes kitchenettes for serving in the dining rooms. The main kitchen is adjacent to the main dining room. The service employs qualified cooks (6.45 am to 5 pm) to cover the seven-day week. Homecare assistants assist with serving meals, dishes, and kitchenette cleaning. All staff have completed food safety training. The four weekly rotating menu is reviewed biannually by a organisationally appointed dietitian. The menu includes mince/moist, pureed options and diabetic desserts. The cook receives a dietary profile for each resident is notified of any dietary changes. Food allergies and dislikes are accommodated. Gluten-free meals are provided. Traditional Māori foods are on the menu including boil ups and fried bread. Lip plates are available to help promote independence with meals.</p> <p>There is a verified food control plan in place which expires 23 March 2022. The temperatures of refrigerators, freezers, inward goods, and cooked foods are monitored and recorded. The chemical supplier monitors the effectiveness the chemicals and function of the dishwasher monthly. All food is stored appropriately, dated and labelled. A cleaning schedule is maintained.</p> <p>The cooks receive feedback from resident meetings and survey results. Residents and the family members interviewed were satisfied with the quality and variety of food served.</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</p>	<p>FA</p>	<p>The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available or the service cannot provide the level of care required.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Seven long-term resident files reviewed identified that an initial assessment and risk assessments had been completed on admission. The interRAI initial assessments and reviews are evident in printed format in all resident files. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	<p>The long-term care plans reflect the outcomes of assessments and describe the resident goals and supports required to meet desired goals in four of seven long-term care plans reviewed. There is a 24-hour multidisciplinary care plan completed that describes the resident's normal routine, habits or behaviours over the morning, afternoon, and nights. There are additional support plans developed as required. Short-term care plans are developed following a change in health, evaluated regularly, and added to long-term care plans if an ongoing problem.</p> <p>Residents and relatives confirmed on interview they are involved in the care planning and review process, however there is no documented evidence of resident/relative involvement in the seven of the long-term files reviewed.</p> <p>There is evidence of allied health care professionals involved in the care of the resident such as physiotherapist, dietitian, continence nurse, podiatrist, cardiologist, mental health services and ophthalmologist.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	<p>Registered nurses (RNs) and care givers follow the care plan and report progress against the care plan at handover and in the written progress notes. When a resident's condition changes the RN initiates a NP or GP visit. If external nursing or allied health advice is required, the RNs will initiate a referral to the appropriate nurse specialist or service. There was documented evidence of relative notification for resident changes to health status such as infections, accident/incidents, medication changes, allied health professional visits including the NP/GP.</p> <p>There are wound assessments, wound management plans and regular wound evaluations for 14 residents with wounds (skin tears, moisture lesions and two pressure injuries). Both pressure injuries of hospital level residents were stage 2 (one facility acquired, and one community acquired). Documentation had not been completed for one (facility acquired) stage 2 pressure injury. The RNs have access to the district nursing service for wound care management advice if required. There is sufficient pressure relieving resources</p>

		<p>available.</p> <p>Staff have access to medical supplies (e.g., dressings). Continence products are available and resident files include a continence assessment and plan as part of the plan of care.</p> <p>Monitoring charts are in use for bowel monitoring, hygiene cares, toileting charts, food and fluid intake, output charts, pain, weight, half-hourly checks, repositioning and neurological observations, however not all neurological observations were completed as per protocol. There were no implemented or documented interventions for one rest home resident with unintentional weight loss.</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 service employs two activity coordinators who are currently progressing through their diversional therapy (DT) qualifications. There is currently a vacancy for the third activity coordinator. There are currently two activity coordinators on each day of the week (one 8.30 am-4 pm and one 9 am to midday) except Sunday when there is one on duty.</p> <p>The integrated activity programme is planned around meaningful everyday activities and special events. Each resident receives a copy of the monthly programme. The programme is flexible, and residents are encouraged to be involved and lead some activities as able. One resident showed his record collection and player and took the activity himself which has now become a regular activity on the programme. There are volunteers involved in the programme who assist with activities and one-on-one time with residents and reading to residents. Activities include (but are not limited to); arts and crafts related to special events, art on the deck, word games, story time, baking, mobile library, pampering, newspaper reading, drawing and happy hour. The residents have their own garden area set up on one of the decks. The activity team make daily contact with residents and offer activities and one-on-one time with residents who choose not to join in group activities. The activity coordinators have initiated allocated visiting time with hospital level residents which includes pampering hands and nails, chats/discussions, reading and activities. These are recorded on a weekly activity sheet for each individual hospital level resident.</p> <p>Community visitors include entertainers, church services, pet therapy and visiting dogs and early childhood centre. A recent initiative has been set up with the early childhood centre to adopt a nanny or papa. An art teacher taught a group of residents' art and drawing. There are monthly van outings into the community. The Sunshine bus or maxi-taxi is used for wheelchair access. The activity coordinators have a current first aid certificate.</p> <p>An activity – 'my profile' is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files reviewed reflected the specific requirements of each resident. Residents interviewed evidenced that the activity programme had a focus on maintaining independence and providing meaningful activities. In the files reviewed the activities plans had been reviewed six-monthly at the same time as the long-term care plan.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission and long-term care plans at least six monthly or earlier if there are significant changes to health. Files reviewed demonstrated that the long-term care plan was evaluated by the RN six monthly, however there was no documented evidence of relative/resident input onto the evaluation (link 1.3.5.3). Relatives interviewed confirmed they had been involved in the MDT (multidisciplinary) review and informed of any changes/supports required to meet the resident goals. The GP/NP completes 3/12 reviews or sooner if required. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected outcomes, the service responds by initiating 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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs or the nurse practitioner. Referrals and options for care are discussed with the family as evidenced in files.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures in place for the disposal of waste and hazardous material. There is an accident/incident system for the investigating, recording, and reporting of all incidents. Chemical supplies are kept safely throughout the facility. The contracted supplier provides the chemicals, safety data sheets, wall charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (PPE) is readily available to staff and in the sluice areas.</p>
<p>Standard 1.4.2: Facility</p>	FA	<p>The building holds a current warrant of fitness, which expires 1 March 2022. The operations manager oversees the daily requests for repairs which are logged into a maintenance book and signed off as</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>completed. Larger repairs require authorisation from the managing director. There is a planned maintenance plan in place which includes two yearly testing and tagging of electrical equipment, functional checks and calibrations of resident related equipment and weekly random checks of resident area hot water temperatures. Water temperatures were sighted to be below 45 degrees Celsius. Local contractors are available 24 hours. Resident rooms are refurbished as they become vacant.</p> <p>Residents have adequate internal space to meet their needs and can safely mobilise with mobility aids or transported in hospital lounge chairs. External areas including large grounds and gardens with mature trees, decked areas, seating and shade are safe to access and well maintained.</p> <p>The care staff interviewed stated they have sufficient equipment to safely carry out the cares outlined in care plans.</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 is a mix of rooms with ensembles, shared bathrooms and hand basins. . There are adequate communal showers and toilets in each of the three “wings”. One of the bathroom/shower rooms is large enough to accommodate a tilting shower chair or trolley if needed. There are vacant/occupied signs, privacy locks and shower curtains in place. Residents interviewed stated care staff respect their privacy at all times</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>	FA	<p>All bedrooms are single and of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Rooms can be personalised with furnishings, photos and other personal adornments as sighted during the tour of the facility.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>The service has a number of lounge/dining areas that are used for activities. There are seating alcoves and a large conservatory that overlooks the river. All internal communal areas are easily accessed by residents and staff. Residents are able to choose where they wish to sit or dine and are able to access areas for</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>privacy, if required. The outdoor areas can be safely accessed.</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>All linen and personal clothing is laundered on site. The laundry has a clearly defined clean/dirty flow. There are two assistants on duty each day who assist with breakfasts, then commence laundry and cleaning duties seven days a week. A homecare assistant operates the laundry from 7.30 am – 1 pm and 4.30 pm – 8 pm. There is an exit door to an area of deck for line drying. A new washing machine and dryer have been purchased since the last audit. All equipment is serviced. Adequate linen supplies were sighted. Chemicals are stored in a locked chemical room which also stores the cleaning trolley when not in use. There is a mixing oasis chemical system.</p> <p>Two homecare assistants interviewed demonstrated knowledge of processes for laundering, cleaning, safe use of chemicals and outbreak management isolation procedures.</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>There is an emergency response and civil defence plan to guide staff in managing emergencies and disasters. Emergency response and first aid is included in the mandatory in-service training programme. There is a first aid trained staff member on every shift. Staff records sampled evidenced current training regarding fire, emergency, and security education. There is a letter from New Zealand Fire Service reviewed dated 9 April 2002, advising approval of the fire evacuation scheme. The last trial evacuation was held in 2021 with the previous training provided six months prior.</p> <p>Information in relation to emergency and security situations is readily available for service providers and residents. There are two fully stocked civil defence kits. There is a gas barbeque should the mains gas supply fail. The service has adequate stored water including water tanks for an emergency. There is a call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible, within easy reach and are available in resident areas including bedrooms, ensuite toilet/s, the lounge and dining room.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	<p>FA</p>	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Some resident rooms open out onto the decks. The facility is heated with radiator heating and underfloor heating and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</p>

environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Leighton House has an established infection control (IC) programme that is implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and is linked into the quality system. A registered nurse is the designated infection control nurse who has been in the role two months and is supported by the clinical manager and national clinical manager. The IC team (RN, care staff, laundry, kitchen, and activity representatives) meet monthly. Minutes are available for staff.</p> <p>The infection control plan and goals are reviewed monthly and annually. Leighton House has a specific goal for 2021 to reduce urinary tract infections (UTI).</p> <p>Visitors are asked not to visit if they are unwell. Covid-19 screening and declarations are in place. There are hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine annually and Covid-19 vaccinations.</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>There are adequate resources to implement the infection control programme at Leighton House. The infection control (IC) nurse has access to expertise within the organisation and supported by the clinical manager. The infection control committee is representative of the facility. External resources and support are available when required including support and advice from the DHB, GPs and Public Health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. Policies are available on the intranet. All Covid-19 information released by the MOH was printed off and made available to staff. The clinical manager had weekly zoom meetings with DCNZ, and the service was updated with outbreak management measures and alert levels.</p>

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The service is committed to the ongoing education of staff and residents. All infection control training has been documented and a record of attendance has been maintained. All newly appointed staff complete infection control orientation and annually as part of the education plan. During Covid-19 lockdown staff were kept informed by daily meetings. Competencies were completed for donning and doffing of personal protective equipment and handwashing competencies.</p> <p>Information is provided to residents and visitors that are appropriate to their needs and safety. Families were kept informed during lockdown of the policies and procedures around alert levels.</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>	CI	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse collates the number of infections monthly and uses the information obtained through surveillance to determine infection control activities, resources, and education needs. Infection control data is reported at the various facility meetings and to DCNZ where benchmarking occurs. Monthly data is analysed for trends and areas for improvement. Internal infection control audits also assist the service in evaluating infection control needs. The GP and the service monitor the use of antibiotics.</p> <p>The service had a suspected respiratory tract outbreak in July 2020 and a rhinovirus outbreak in April 2021. The initial five residents with symptoms of rhinovirus had Covid-19 swabs taken which were confirmed negative. In both outbreaks the facility was in lockdown and the Public Health informed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint policy in place that states the organisations' philosophy to restraint minimisation. The philosophy is to be restraint free, however the service will use restraint if there is a need for resident safety. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Currently the service has one resident requiring the use of a restraint (tray table) and no residents use an enabler. Staff have training around restraint, enablers, and management of challenging behaviour annually with training records indicating that this has occurred for staff.</p>
Standard 2.2.1: Restraint	FA	The restraint coordinator for the facility is the clinical manager (registered nurse) who has defined responsibilities included in their job description. The restraint coordinator was able to describe their role in

<p>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>provision of education, monitoring of restraint use and implementation of the policy.</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>Restraint assessments are based on information in the care plan, family and/or enduring power of attorney discussions (with resident input if possible) and on observations of the staff and service delivery. A restraint assessment tool is completed for residents requiring an approved restraint. Ongoing consultation with the resident and family was also identified. . A restraint assessment form was completed for the one resident requiring restraint (reviewed as part of the audit). The assessment considered the requirements as listed in criterion 2.2.2.1 (a) - (h) and identified the specific interventions or strategies that had been tried prior to the assessment for restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation with the resident (as appropriate), family/whānau, GP/NP and the restraint coordinator. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint use is used as a last resort in-keeping with the restraint minimisation policy. A restraint register is established and this records information to provide an auditable record of restraint use.</p> <p>The resident file reviewed requiring the use of a restraint, evidenced that consent was obtained on consultation with the family member with this signed by the family member, restraint coordinator and nurse practitioner.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Audits are completed six-monthly. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at</p>

episodes of restraint.		the monthly clinical meetings and quality meetings. A organisational review of the restraint minimisation and safe practice process occurs six monthly.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Audits are completed six-monthly. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly clinical meetings and quality meetings.

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	All aspects of the quality programme are included in the meetings apart from complaints. Three of four complaints in 2020 and 2021 were not tabled or discussed at meetings or documented through the staff bulletins. The theme of one of four complaints reviewed was documented in the quality bulletin as a complaint, however there was no discussion of improvements that could be made for the service.	Complaints are not linked to the quality programme in order for improvements to be made.	<p>Link complaints into the quality programme so that improvements can be made.</p> <p>180 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	An internal audit programme with an annual schedule is in place. Audits that relate to the operational manager include corrective action plans and evidence of resolution of issues. Clinical audits have been completed in a timely manner; however corrective action plans have not been raised for those completed since January 2021 until May 2021.	Corrective action plans and evidence or resolution of issues identified through clinical audits have not been completed in a timely manner for those completed in 2021.	<p>Document corrective action plans for clinical audits in a timely manner, and evidence resolution of issues.</p> <p>90 days</p>

implemented.				
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medication charts on the electronic system met prescribing requirements for regular and 'as required' medications. Medication charts are reviewed at least three monthly. Photo identification is on all charts, however not all charts had an allergy status documented.</p>	<p>Six of 14 medication charts did not record an allergy status.</p>	<p>Ensure all medication charts identify an allergy status.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Long-term care plans reflected the outcomes of assessments and document supports/interventions in four of the seven care plans reviewed.</p>	<p>There were no documented interventions for three rest home residents; (a) one resident with back pain requiring 'as required' analgesia and GP reviews, (b) management of seizures for resident with a recent admission for grand mal seizure and (c) there was no diabetic management plan for a resident on insulin.</p>	<p>Ensure supports/interventions are documented to support the resident's current health status.</p> <p>90 days</p>
<p>Criterion 1.3.5.3</p> <p>Service delivery plans demonstrate service integration.</p>	<p>PA Low</p>	<p>Residents/relatives interviewed confirmed they were involved in the development and evaluation of care plans, however there was no documented evidence of resident/relative input in the seven care plans reviewed.</p>	<p>There was no documented evidence the resident/relative had been involved in the development and evaluation of long-term care plans.</p>	<p>Ensure there is documented evidence of resident/relative involvement in care planning.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>All identified wounds including two pressure injuries had a wound assessment plan in place, but one pressure injury was not linked to the care plan and there was no accident/incident form completed. Residents with unwitnessed falls were assessed by RNs in a timely manner and commenced on neurological observations, however not all neurological observations had been completed as per policy. All residents had monthly observations including a monthly weigh but there were no implemented or documented interventions for one resident with unintentional weight loss.</p>	<p>(a) The presence of a stage 2 facility acquired pressure injury (rest home resident) had not been reported on an accident/incident form and was not linked to the long-term care plan.</p> <p>(b) Ten of twenty-two neurological observations commenced for unwitnessed falls had not been completed as per protocol for 24 hours.</p> <p>(c) There were no implemented or documented interventions in place for one rest home resident with over 5% weight loss in one month.</p>	<p>(a) Ensure pressure injuries are reported on an accident/incident form and are documented into the long-term care plan.</p> <p>(b) Ensure neurological observations are completed as per protocol for unwitnessed falls.</p> <p>(c) Ensure interventions are implemented/documentated for unintentional weight loss.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.4.2</p> <p>Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.</p>	CI	<p>Managers and staff have worked to improve satisfaction with cultural values and beliefs following a low level of satisfaction expressed in the 2020 resident survey.</p>	<p>There are links to the local marae. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. There are 50% of staff that identify as Māori including the operations manager who provides leadership for the service. Staff identify with different iwi including Ngāti Porou. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All care staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>The activities programme includes activities that reflect Māori. Guests to the service include a kapa haka/performer and teacher of traditional Māori dance, a teacher and carver/ kaumātua who carves and displays art work with teachings around tikanga, purakau and stories of Tairāwhiti, and a raranga/weaver and tutor of Māori medicine. Food services have been improved to include traditional food prepared as a celebration by residents on Waitangi Day with other food such as boil ups added on a regular basis to</p>

			<p>the menu.</p> <p>The satisfaction survey completed in 2020 showed that only 50% of respondents strongly agreed that their cultural values and beliefs were being met. A corrective action plan was put in place. As a result, admissions of residents who identify as Māori or Pacific Island have increased by 25% from 2020 to January 2021. The satisfaction survey completed in April 2021 showed that 80% of respondents were very satisfied with cultural activities with all others (bar one) stating that they were satisfied that their cultural values and beliefs had been met.</p>
<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>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>	<p>The service implemented the following strategies around reducing the incidents of urinary tract infections (UTIs) that included: (a) education on the importance of hydration; (b) education session presented by a microbiologist at clinical managers' conference on the prevention and management of UTIs; (c) introduction of extra fluid rounds in warmer weather and (d) establishing a toileting regime that meets individual resident's needs. As a result of the strategies implemented, the facility has remained below the organisational target range of 1.51 UTIs per 1000 bed nights at 1.36 over a twelve-month period.</p>

End of the report.