

The Kawerau Social Services Trust Board - Mountain View Home & Hospital

Introduction

This report records the results of a Surveillance 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:	The Kawerau Social Services Trust Board
Premises audited:	Mountain View Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 May 2021 End date: 19 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:	49



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

Mountain View Home and Hospital is owned and operated by Kawerau Social Services Trust which also owns the small retirement village on site. The home provides rest home and hospital level care to a maximum of 54 occupants.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of policies and procedures, the review of residents' and staff files, observations, interviews with residents, family members, management, staff and a general practitioner.

The only change to the service since the previous audit is a change in facility manager in October 2020. This was appropriately notified to the DHB and the Ministry of Health (MOH)

The two actions required at the partial provisional audit in September 2020 (code of compliance and fire evacuation scheme) were verified as completed and closed. There were no areas for improvement raised at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Implemented systems and the environment is conducive to effective communication. There were no residents on site who required interpreters, and staff adhere to the principles of open disclosure by making appropriate notifications following unwanted events.

The complaints management system meets the requirements of the Code and is known by staff, residents and their families. Residents and family members interviewed reported that the manager immediately responds to and addresses any concerns they raise.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The annual business and quality risk management plans include the scope, direction, goals, values and mission statement of the organisation. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes the monitoring of service delivery and other operations through internal audits. Quality improvement data is collected, analysed for 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.

The appointment, orientation and management of staff are based on good employment practices. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual staff performance reviews.

Staffing levels and skill mixes meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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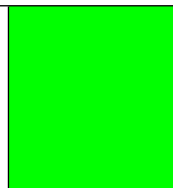
Policies and procedures provide guidelines for access to services. Residents are assessed prior to entry to the service to confirm their level of care, and at least six monthly or sooner as resident's needs change. The nursing team is responsible for assessment, development, and evaluation of care plans. Care plans are developed in consultation with residents and family/whānau.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is an appropriate medicine management system in place. Three monthly medication reviews are conducted by a general practitioner (GP) and these were current. Staff involved in medication administration have been assessed as competent to do so.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. The menu has been recently reviewed by a dietitian and recommendations are under review. The food safety plan is being implemented, as verified by the Kawerau District Council during audit.

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.

There have been no changes to the structure of the buildings since the partial provisional audit in September 2020. A current building warrant of fitness is on display and planned and reactive maintenance is occurring.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

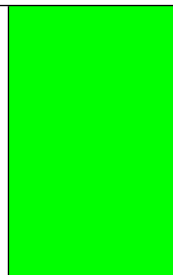


Standards applicable to this service fully attained.

The service meets the requirements of the restraint minimisation and safe practice standards. On the days of audit, four residents had restraint interventions in place and there were no residents using enablers.

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.

Aged care specific surveillance is undertaken, data is analysed, and results reported and communicated to staff at the staff meetings. Follow-up action is taken when required. There is a low infection rate.

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	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and procedures meet the requirements of this standard, the provider's contract with the DHB, and Right 10 of the Code. It also contains references to advocacy and the organisation's quality system, resident's rights, advocacy and resident/family meetings policies.</p> <p>Review of the complaints register and interview with the facility manager confirmed there had been one formal complaint received in the past 12 months. The records showed that this was acknowledged in writing, investigations occurred and all parties were kept informed. The event was managed in a timely way and resolution reached within three days.</p> <p>The recommendations made by the office of the Health and Disability commissioner following a 2018 complaint investigation, have all been implemented. These included a written apology to the family/whanau involved, ongoing staff education in specific topics and using the case as a learning tool for registered nurses (RNs), updating of policies and procedures and regular audits of wound management.</p> <p>Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Code. The residents and relatives interviewed demonstrated an understanding and awareness of complaint processes. Staff attend regular education on the Code of Rights, including the complaints processes. Review of residents' meeting minutes provided evidence of discussion on the Code of Rights and complaints.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The family members interviewed said they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents. Communication about the outcomes of, and invitations to participate in regular or urgent medical reviews were forthcoming. This was supported in the residents' records reviewed. Staff and the two managers interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There were no residents on site for whom English was a second language. Policy describes procedures for accessing interpreters. A number of staff are fluent in Te Reo and Cook Island Maori which reflects the resident population.</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>	<p>FA</p>	<p>The annual business plan includes service goals which are being monitored for progress by the facility manager and the board. The business plan includes a mission statement, values and service scope and identifies the organisation's strengths, weaknesses, opportunities and threats. The sample of board meeting minutes confirmed that the board are kept fully informed about residents, occupancy, staffing, adverse events and other aspects of service provision.</p> <p>Mountain View Home and Hospital is governed by an eight member Board of Trustees, and day to day operations are overseen by a facility manager (FM) who is a registered nurse (RN) with a current practising certificate. This person has been employed at Mountain View for 10 years in senior clinical roles and was appointed as manager in October 2020. Personnel records and interview with the manager confirmed their nursing portfolio. Clinical skills and knowledge are maintained by attending networking meetings with other aged care providers and regular professional development/education in subject areas related to management of an aged care service. The manager is supported by two charge nurses, an operations manager, and an administrator/receptionist. There is also a team leader for food services, and other allied staff for resident activities, housekeeping and building maintenance. A previous, long serving manager has been contracted by the board to provide consultancy and ongoing support to the new facility manager for 16 hours each month.</p> <p>Both charge nurses have been working at Mountain View for nine years and oversee the care provided to residents by the other RNs and caregivers. They attend industry specific training to maintain the skills and knowledge required in the aged residential care contract (ARCC). Maximum occupancy is now for 54 residents after the addition of four more hospital beds in 2020.</p> <p>The organisation has agreements with the Bay of Plenty District Health Board (BOPDHB) to provide hospital-medical and geriatric and rest home level aged care, respite services, Long Term Support-Chronic Health Conditions (LTS-CHC) and a community day programme. The community day activity programme is in abeyance. Services are configured for 36 hospital level beds (including two dual purpose beds) and 18 rest home level beds, to a maximum 54 occupants.</p>

		<p>On the day of audit 49 residents were receiving services under the age residential care contract (ARCC). Thirty three residents were assessed as requiring hospital level care and 16 as requiring rest home care. One hospital resident was under the age of 65 and funded as LTS-CHC.</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>	<p>FA</p>	<p>The documented quality and risk management system is well embedded in practice and reflects the principles of continuous quality improvement. Policies 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 currently known best practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Service delivery is monitored through complaints, internal audit activities, regular resident and relative satisfaction surveys and the organisation's reporting systems which utilise a number of clinical indicators such as incidents and accidents; surveillance of infections; pressure injuries; falls data and medication errors.</p> <p>Quality improvement data is collected, collated and analysed to identify trends. Where audits or quality data indicate the need for improvement, corrective action plans are developed, implemented, and evaluated before being closed out. There is communication with staff of any subsequent changes to procedures and practice through meetings and staff notices. A range of meeting minutes (quality, health and safety, and staff meetings) confirmed how this information is reported and discussed with all levels of staff. Residents and family are notified of relevant updates via resident meetings or newsletters.</p> <p>Staff reported their involvement in quality and risk management activities through their participation on committees and assisting with internal audits.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey results from July 2020 (11 responses from family and 23 from residents) revealed 86% satisfaction with services. 100% of respondents said they would recommend Mountain View to others. Individual comments were reported to relevant departments/staff and followed up for actions by the FM. Residents and family members interviewed were happy with the frequency of consultation.</p> <p>The organisation has a risk management programme implemented which records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. The hazard register sighted was current and is kept updated.</p> <p>Staff are provided regular education on health and safety matters and are supported in the workplace to keep themselves free from injury. There had been no staff injuries that required reporting to Worksafe in this certification period.</p> <p>Managers and the board are aware of the processes for the identification, monitoring, review and reporting of risks</p>

		and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and follows requirements.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The adverse event reporting system continues to be a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. These were reported verbally at handover and in the written summary. Incidents are reviewed by the charge nurses who investigate and document follow up actions. A summary of categorised events is submitted to the manager who reports these to the board monthly. The designated RN champions for each risk area (for example, infections, restraint, falls, nutrition, wounds, and opioid use) also analyse and review incidents that impact their area of interest. Outcomes from investigations and analyses are discussed at monthly RN meetings. The FM compiles annual evaluative reports on the number of hospitalizations, resident falls, nutrition, infections, restraint, antipsychotic and opioid use, which provide comparative data on positive or negative trends, and discuss the interventions taken to remedy unwanted trends.</p> <p>Section 31 notifiable events for stage three pressure injuries were submitted to MoH and the DHB on 07 August 2020, and 06 May 2020.</p> <p>There was evidence in the sample of records reviewed and by interviews that the staff understood and implemented open disclosure practices by acknowledging and notifying events to all relevant parties (for example, to family/whanau and the GP).</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>	FA	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Police vetting of volunteers also occurs. A sample of 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 show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on tri-annual basis by the hospital charge nurse and included annual mandatory training requirements such as emergency planning, fire drills, infection control, medicine competency and manual handling. Care staff have either completed or are progressing a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 43 Caregivers, 11 have achieved level 4 of the national certificate in health and wellness, 12 are at level 3, seven at level 2 and 12 are at level 1. The diversional therapist completed the required education six years ago and a new activities assistant has commenced the level 4 qualification in diversional therapy. Kitchen staff have unit standards 167 and 168 in safe food handling and the new chef has the city and guilds national certificate in hospitality management.</p>

		<p>Each of the seven RN's employed (including the facility manager) are certified to complete interRAI assessments and are maintaining their annual competency with this. All RNs are maintaining current first aid certificates.</p> <p>All staff engage in regular performance appraisals as required by the ARC contract.</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>	FA	<p>The staff availability policy describes the service provider's approach to staffing. It states that staffing will be evaluated at least annually or when change occurs in residents, core business, goals or size. Reviews and adjustments to staffing have occurred a number of times during this certification period.</p> <p>A sample of rosters and interviews with clinical and care staff, residents and families, confirmed there were sufficient numbers of staff on each duty to meet residents' needs. RNs and carers said they are offered extra hours when there are more residents with higher levels of need. On the days of audit, the staff allocation (for 23 hospital residents) was one RN on the floor 24 hours a day and seven days a week (24/7) plus the RN charge nurse who works 32 hours per week Tuesday to Friday. There were four caregivers rostered on each morning, and three in the afternoon. Staff allocated for care of rest home residents are the Charge Nurse who works 32 hours per week Monday to Thursday, three caregivers in the morning, and two in the afternoon. Putauaki, an open wing for up to 10 people with confusion and memory loss is allocated two caregivers with RN oversight and other short shift carers. One RN and two care givers are rostered on for each night shift.</p> <p>The RN manager who lives on site, is employed to work five days a week between the hours of 8am to 5pm and shares the 24/7 on call with the charge nurses.</p> <p>There are seven cooks who work various hours seven days a week. The diversional therapist and an activities co-ordinator are employed for a total of 54 hours a week to provide group and individual activities. Frequent and reliable community volunteers also contribute to the activities programme. The volunteers complete an orientation programme and sign confidentiality agreements. Other allied staff, such as the cleaners, laundry staff, administrator and maintenance/grounds staff, are employed for enough hours to complete their tasks.</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</p>	FA	<p>The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. The service provider has introduced an electronic medicine management system since the last audit, and also changed the method individual resident pre-packaged medicines are provided in. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the registered nurses (RNs) and/or general practitioner when the resident is transferred back to service from hospital or any external appointments. Medication competencies had been completed annually for all staff administering medication, as verified by the lead auditor.</p> <p>There were two residents self-administering medicines at the time of the audit. The self-administration medication policy and procedure provides guidance on the required processes to ensure resident suitability and safety to self-</p>

<p>safe practice guidelines.</p>		<p>manage medicines. The applicable assessment forms had been completed and approved by the GP. A resident interviewed is self-administering inhalers, had sound understanding of processes and medicine use requirements and stores the medicines safely.</p> <p>The name of the prescriber, dates of commencement and discontinuation of medicines were documented on the medicine records sighted. The GP reviewed medicines within the required timeframes. Allergies were clearly indicated, and all residents' photos were current for easy identification. All expired medications were returned to the pharmacy in a timely manner.</p> <p>A caregiver and a registered nurse were observed to be administering medicines safely, following the required medication protocol guidelines and legislative requirements.</p> <p>The controlled drug register was current and correct. There is a weekly check of the balance and a quantity stock count completed at the end of December 2020. Controlled drugs (CDs) are stored securely. Monitoring of medicine fridge temperatures is conducted regularly and readings are within the required range. There are no vaccines stored on site. The GP reviews residents' medications at least every three months.</p> <p>The outcomes of PRN (as required) medicines administered were documented in either the medicine records or progress notes sampled.</p> <p>Mountain View Home and Hospital has commenced a programme to review the use of antipsychotic medicines (started early 2020) and opioid medicines (commencing May 2020). The data is being collected and collated, and reported quarterly, with the goal to ensure residents pain and behaviours are managed appropriately and with consideration of non-pharmacological means.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by ten staff who cover the seven day week. The main meal is provided at lunchtime. There is a four-week summer and winter menu in use. The winter menu has been recently reviewed by a registered dietitian in April 2021. The service is currently reviewing the dietitian's recommendations. Food supplies are ordered by designated staff from approved suppliers. The cook advises there is at least five days food available at all times for use in an emergency.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is a template food control plan in use. Mountain View Home and Hospital has been verified as being compliant with this, by way of an audit of food services by Kawerau District Council on 14 June 2020. A re-audit is not required for 18 months.</p> <p>Food temperatures, including high risk items are monitored appropriately and recorded. Applicable staff have completed relevant food handling training as verified by the lead auditor.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a nutritional profile is completed. Individual resident's dietary profiles are updated as required and communicated</p>

		<p>verbally if urgent. The kitchen staff confirmed having access to this information and summary lists of residents with specific dietary needs are displayed on the wall in the kitchen. Personal preferences, any special diets and any modified texture requirements are made known to staff and accommodated in the daily menu plan. Special equipment to meet residents' needs is available.</p> <p>Evidence of food satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>All residents are weighed at least monthly, and trends of weight gain and weight loss are monitored, with body mass index (BMI) recalculated for applicable residents. An annual summary is documented detailing overall themes and trends per month in 2020, and noted a comparison with the previous year.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans reviewed have sufficiently detailed interventions to address the identified needs of residents.</p> <p>Significant changes were being reported to the registered nurses and general practitioner in a timely manner and instructions/prescribed orders carried out. The facility manager and charge nurses reported that the GP's medical input was sought within appropriate timeframes, that medical orders were followed, and care was resident centred. This was verified by the GP during interview, who confirmed being available on call, that staff contact the GP appropriately and residents are provided with appropriate and timely care. The two charge nurses are very experienced. Care staff confirmed that care was provided as outlined in the care plan and / or communicated verbally. Wound care charts are utilised with photographs to provide a visual picture of how resident wounds are improving or otherwise.</p> <p>A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are normally provided by two staff and activities team leader (has been in this role for approximately 18 years), and an activities coordinator who commenced in February 2020. The activities team works Monday to Saturday with two staff on duty Tuesday to Thursday.</p> <p>The activities are based on individual resident assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. These assessments were completed within two weeks of admission in consultation with the family and residents. A weekly activities planner is developed, and each resident is given a copy of the planner. The day's activities were being promoted to remind residents and staff and were noted on a whiteboard in the main lounge area. In response to Covid-19, the rest home and hospital resident residents are still being kept in 'bubbles', to minimise potential resident risk. At the current National Alert Level One, residents are able to participate in church services, or watch entertainers, although do so socially</p>

service.		<p>distanced (on different sides of the large dining/lounge room).</p> <p>The activity programme is formulated by the activities staff in consultation with residents and family/whānau. The activities were varied and appropriate for residents receiving rest home and hospital level of care. A daily record of participation / attendance is maintained, and a summary comment noted monthly in the residents' files. There is a formal evaluation of the resident's participation as part of the six-monthly care plan review or annual multidisciplinary review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented at least each shift, or sooner where applicable, by care staff in the progress notes. Changes in residents' ability, health or mood, as noted by the caregivers, were reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals, occurs every six months or sooner if residents' needs change. These evaluations were carried out by the RNs in conjunction with family, residents, GPs, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Residents' records sampled evidenced that there was monitoring of pain assessments, neurological observations following falls, behaviour monitoring, elimination needs, and evaluation of a range of laboratory tests requested where clinically indicated. Short term care plans and wound care plans were reviewed at least weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau were included and informed of all changes.</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 12 November 2021) is publicly displayed. There have been no changes made to the structure of the building since the previous partial provisional audit in 2020 when four new rooms were added to the hospital wing.</p> <p>The service obtained a code of compliance certificate for this (sighted and dated 15 October 2020) which was required as a follow up to the partial provisional audit.</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 is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff and residents confirmed they know the processes they should follow if any repairs or maintenance is required. They said requests are appropriately actioned and that they are happy with the environment.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A corrective action identified at the September 2020 partial provisional audit required the evacuation scheme to be reviewed. A letter dated 20 October 2020 from the local branch of Fire and emergency Services NZ, stated there was no need to amend the current staged evacuation scheme which was approved in 2005. This matter is now closed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The hospital area charge nurse has been the designated infection prevention and control coordinator (IP&CC) for approximately five years and is responsible for the infection control surveillance and monthly reporting to management and staff on any results. Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract, eye, gastro-intestinal, respiratory tract, skin infections and 'other'. The IP&CC reviews all reported infections, and these were documented. Any new infections and any required management plans are discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Definitions of infection are used, and laboratory results when available. Results of surveillance are shared with staff via the staff meetings and at staff handovers. Graphs are produced that identify any trends by month, and the comparisons against previous months. Follow-up actions required are noted. There is a very low infection rate. There have been no outbreaks of infection since the last audit.</p> <p>Consenting staff and residents are provided with annual influenza vaccinations. The Covid-19 vaccination programme is underway at Mountain View Rest Home and Hospital with the first dose of Covid-19 vaccine already administered to consenting staff and residents.</p> <p>The GP confirmed staff bring any concerns about a resident with possible infection to them in a timely manner.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	FA	<p>The service policies meet the requirements of these standards and provide clear guidance on the safe use of both restraints and enablers. On the day of audit, four residents required restraint interventions. All required bed rails raised for safety when in bed and one of these also required a lap belt when seated. There were no enablers in use. Staff and the restraint coordinator interviewed understood the voluntary nature of enablers.</p> <p>The restraint coordinator who is the rest home charge nurse, provides support and oversight for enabler and</p>

restraint is actively minimised.		restraint management in the facility. This person demonstrated a sound understanding of the organisation's policies, procedures and practice and what was required of their role and responsibilities. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the RN, quality and staff meeting minutes, resident files and from interviews with staff.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.