

Rawhiti Estate Limited Partnership - Rawhiti Estate

Introduction

This report records the results of a Provisional 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: Rawhiti Estate Limited Partnership

Premises audited: Rawhiti Estate

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

Dates of audit: Start date: 24 June 2021 End date: 25 June 2021

Proposed changes to current services (if any): This provisional audit was completed to assess the suitability and preparedness of the prospective new owners

Total beds occupied across all premises included in the audit on the first day of the audit: 60



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.

General overview of the audit

Rawhiti Estate provides rest home, dementia and hospital level care for up to 122 residents. There were 60 residents on the day of audit.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

The manager/registered nurse is appropriately qualified and experienced and is supported by a clinical manager/registered nurse and the directors. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

The sale of the business has occurred as a result of the initial investors being bought out and being replaced by a Limited Partnership structure. The CEO, Property Officer and CFO of the previous company now have a larger share of the assets in the new company, and now have more managerial influence and control of the new entity.

All current policies, systems and staff will remain in place following the purchase. There will be no changes to the service, the operational structure, management or staff. Changes will be that the new structure has engaged a consultancy to review and assist overseas staff with visas to work through process with the aim of retaining staff.

There were no areas for improvement were identified as a result of this audit.

Consumer rights

Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome information includes information about the Code. Residents and families are informed regarding the Code and staff receive 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 making 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, which meets timeframes established by HDC.

Organisational management

Services are planned, coordinated, and are appropriate to the needs of the residents. The manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews.

A quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

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. Ongoing education and training for staff includes online training, in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

Continuum of service delivery

The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The diversional therapists (lifestyle coordinators) have developed an activity programme to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home, hospital and dementia care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and had been reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being available 24 hours per day.

Safe and appropriate environment

The building has a current building warrant of fitness and all external areas were accessible and of an appropriate standard. There is a preventative and planned maintenance schedule in place. Ongoing maintenance issues are addressed. Chemicals are stored safely on site. Cleaning and maintenance staff are providing appropriate services and are well monitored through the internal auditing system. Laundry is outsourced to an external provider.

All resident rooms are spacious; each with a full ensuite to ensure safe care and support is provided to all residents. Communal areas are well designed and spacious. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas in each wing. The internal areas are appropriately ventilated and heated. The outdoor areas are safe, easily accessible and secure for the wing that requires this.

Systems and supplies are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no

residents requiring the use of a restraint or an enabler. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

The infection control management system is appropriate for the size and complexity of the service. The infection control coordinator (clinical manager) working together with the clinical coordinator, general manager and registered nurses, is responsible for coordinating and providing education and training for staff. The infection prevention and control programme include policies, standards and procedures to guide staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff and residents are offered the annual flu vaccine and have received the first dose of the Covid-19 vaccine. There have been no outbreaks.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Policies and procedures are implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as a regular training topic. Interviews with three managers (general manager/RN, clinical manager/RN, and one director) and twenty staff (seven care support staff (caregivers) that work across all three levels (rest home, hospital and dementia) on both the am and pm shifts, nine registered nursing (RN) including the clinical coordinator, one chef, one housekeeper and two activities staff) confirmed their understanding of the Code. Staff could provide examples of how the Code applies to their job role and responsibilities.</p> <p>Five residents interviewed (three rest home and two hospital) and five relatives (one rest home, two hospital and two with a family member in the dementia unit) confirmed that staff respect their privacy and support them in making choices.</p> <p>Interview with the purchaser a (director) and the general manager</p>

		confirmed that the prospective owners have a good understanding of implementation of the code of resident rights.
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy, and in eight files reviewed, (three hospital, three dementia level and two rest home residents), all residents had informed consent documentation (part of admission agreement) signed on file. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.</p> <p>There was evidence in files reviewed of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies of EPOAs were on resident files where available.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Details relating to advocacy services are addressed in their compendium, available in each resident room. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes include opportunities to attend events outside of the facility. Residents are supported and encouraged to remain actively involved in community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are in the resident's compendium, accessed in each resident room. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). There have been no complaints lodged since the previous audit. Previous records reviewed identified a process of follow up and outcomes.</p> <p>The complaints process is linked to the quality and risk management systems being implemented. Staff are kept informed of complaints received and participate in training where indicated.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides comprehensive information to prospective residents and families including information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them on the Code. The manager and/or clinical manager discuss the Code with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</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</p>	<p>FA</p>	<p>A tour of the service confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering residents' rooms and keeping doors closed when cares were being provided.</p>

independence.		<p>The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning processes. This includes family involvement. Interviews with residents confirmed their values and beliefs were considered.</p> <p>Staff could describe definitions around abuse and neglect that aligned with policy. Staff training on abuse/neglect is provided at orientation and as a regular training topic. Residents and relatives interviewed confirmed that staff treat residents with respect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Policies provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with Ngati Whatua Orakei marae with a designated Māori liaison contact person. Resident rooms are blessed following a death in line with the resident's preferences/religion. One resident identified as Māori; the resident's file included culturally appropriate care plans and the resident agreed that they felt culturally safe.</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>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Care plans are detailed and individualised to reflect the resident's specific needs, likes and dislikes.</p> <p>Six monthly multi-disciplinary team meetings are scheduled to assess if resident needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs.</p>
Standard 1.1.7: Discrimination	FA	<p>Staff job descriptions include the job role and responsibilities. Staff sign a code of conduct during their induction to the facility, evidenced in all</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>seven staff files reviewed. Meetings with staff included discussions on professional boundaries and concerns as they arise. Interviews with managers and staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>This purpose-built facility has been designed to deliver resident-centred care. A master copy of policies purchased through an external consultant have been edited to fit the purpose of Rawhiti Estate and are implemented in line with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>A range of clinical indicator data is collected against each service level. It is collated, monitored and benchmarked against other aged care facilities. Examples of indicators include resident adverse events, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction.</p> <p>Staff training is evident and includes both in-services and online learning. Training packages include monitoring staff competency. Attendance is tracked.</p> <p>The call bell system can be activated via a pendant that each resident wear, and via the checked in care electronic system.</p> <p>Satisfaction survey results (October 2020) reflected 100% satisfaction around: a high standard of care, cleanliness, friendly staff. Other areas also reflected a high level of satisfaction, however, the service had developed and implemented action plans to address lower scores in areas such as activities, use of technology, and meals, as examples.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Ten incident forms reviewed indicated that this requirement is being met. Family members interviewed confirmed they are notified following</p>

		<p>a change of health status of the resident or following an adverse event. There is an interpreter policy in place and contact details of interpreters were available.</p> <p>Residents and family interviewed praised the high level of communications through emails, TXT, phones calls and face to face. They noted that they felt very well informed during recent Covid-19 lockdowns. Families all praised the general manager for approachability and actioning requests.</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>Rawhiti Estate provides rest home, hospital (including medical) and dementia level care. There are a total of 122 beds in the facility including 48 dual purpose beds (hospital or rest home level of care) in the care centre which is located across two levels. There are 20 dedicated dementia level beds on level two. There are also 27 independent living units certified to provide rest home level care, this includes for couples if needed. Occupancy on the days of audit was 60 residents. This included 19 residents in the memory loss unit (dementia care), 15 requiring rest home level of care and 25 requiring hospital level of care. There was also one resident who was privately paying and not assessed. All others were under the Age-Related Care contract. There were no residents under the medical component of certification and no residents under the age of 65 years. There were no residents in the certified independent living units identified as being under the ARRC agreement.</p> <p>The care centre is divided into four neighbourhoods. Care suites are chosen for purchase in any of the dual-purpose neighbourhoods for rest home/hospital level of care and in the memory loss unit for dementia level of care. The resident retains all the rights to the occupation of the care suite under the occupation rights agreement.</p> <p>A business plan is developed (2020-2022) with evidence of a review occurring annually. Strategies that continue include falls reduction, enhancing resident engagement with technology (checked in care (resident tablet), vocera utilisation), and addressing continence in the dementia unit.</p> <p>The manager is a registered nurse (RN) with management and auditing</p>

		<p>experience in the aged care industry. The manager has been employed since the planning stage of Rawhiti Estate. The clinical manager is an RN who has worked at Rawhiti Estate for three years and has been the clinical manager since April. The service has also recently appointed a clinical coordinator. The managers are supported by the directors who are actively involved in business operations.</p> <p>Provisional:</p> <p>Relevant authorities have been notified of the pending change of ownership. The prospective owners have been in contact with the portfolio manager for the DHB. The tentative date of sale is 1 July 2021. The process of moving from equity funding to a limited partnership means that the company assets have been sold to a new entity and a different group of investors. The current CEO, CFO and Chief Property officer (All Directors) have reinvested in the new company and have more control over their assets. The directors have owned Rawhiti Estate since its conception and have previous experience managing large national older people care home companies. There are no planned changes to staffing or systems and processes.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager fulfils the general manager's role during the temporary absence of the general manager. During the audit it was observed that additional support is available by the chief executive officer (CEO) and the chief property officer.</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>	FA	<p>Rawhiti Estate is implementing a quality and risk management system that is directed by a software package developed by an external consultant. Quality and risk performance is reported across the range of facility meetings and also to the organisation's board of directors. Discussions with the managers and staff and review of management and staff meeting minutes reflected everyone's involvement in quality and risk management activities.</p> <p>Resident meetings are scheduled two-monthly. Resident and relative surveys were completed prior to the previous audit (October 2020). Results were collated and analysed with results shared with staff and</p>

	<p>residents/relatives.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Internal audits are completed each month as per the audit schedule. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Corrective actions are logged on a corrective action register and are signed off when implemented. Quality and risk results are communicated to staff across a variety of meetings and reflect actions being implemented.</p> <p>Health and safety policies are implemented and monitored. The Chair of the Health and Safety Committee is the Village Administration Manager and there are six health and safety committee members . The five health and safety committee members include maintenance, housekeeping and care support. Risk management, hazard control and emergency policies and procedures are in place.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. All contractors are inducted to health and safety processes electronically at reception. New staff are also inducted and orientated to the health and safety programme. Health and safety is a regular agenda item at all resident and staff meetings. Health and safety information (e.g., new hazards, staff injuries) are analysed and reported monthly to the Board.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling from the time of admission.</p> <p>Interview with the purchasers confirmed that there will be no changes to the current quality management system and performance monitoring programme. Transition plans have been implemented around change of ownership. These have included changes to the food control plan to</p>
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		reflect the new entity, and changes to the New Zealand Companies office registration.
<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>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed electronically for residents and in hard copy for staff accidents.</p> <p>A review of ten resident incident/accident reports including: witnessed and unwitnessed falls and behaviours that challenge, identified that all were fully completed and include follow-up by a registered nurse. The managers (general manager, clinical manager) are involved in the adverse event process. Meetings and handovers during the week provide an opportunity to review any incidents as they occur. Neurological observations are implemented for unwitnessed falls.</p> <p>The general manager is able to identify situations that would be reported to statutory authorities. There have been no notifications since the previous audit (other than the change of ownership).</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>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. All nine staff files reviewed (three caregivers (care support), one clinical manager, one clinical coordinator, two staff registered nurses, one activity person and one housekeeper) included signed contracts, job descriptions relevant to the role the staff member is in, police checks, inductions, application forms and reference checks. Staff performance appraisals were documented for staff who had been at the service for over a year. There are 24 volunteers, and many residents employ a care companion, five volunteer files and two care companion files all documented an orientation and relevant checks.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practising certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide</p>

		<p>evidence of current registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. This programme is specific to worker-type. Caregivers are buddied with more experienced staff. Staff are given six weeks to complete their orientation programme. Competencies are included in orientation (e.g., hoist transfers, the electronic call system (vocera), emergency procedures, hand hygiene, medicine management).</p> <p>There is an implemented annual education plan and staff training records are maintained. Staff have completed on average 3.5 hours per month of online training. In-service training is also offered on a range of topics each month and include external speakers. Registered nurses are supported to maintain their professional competency.</p> <p>Eleven of twelve registered nurses have completed their interRAI training. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the facility and on outings. There are 13 staff who work in the dementia unit, nine have achieved the dementia unit standards and four are in progress. There are 24 staff who have achieved the dementia unit standards at Rawhiti, the service has ensured a high level of dementia training for all staff. All four activities staff (lifestyle coordinators) have completed a diversional therapy qualification.</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. The general manager and clinical manager work Monday – Friday.</p> <p>There are four neighbourhoods which wrap around a central atrium and they are located across two floors. The neighbourhoods on level 2 are Rakau (14 beds with occupancy of 11 hospital level care and one rest home) and Ranui (Memory Loss) with 20 beds with occupancy of 19 dementia level of care) and on Level 3 Orakei (20 bed occupancy with occupancy of seven hospital level of care and ten rest home level of care including one resident private paying and not assessed) and Upland (14 beds with an occupancy of seven hospital level of care and</p>

		<p>five rest home level of care).</p> <p>Staffing depends on acuity and numbers of residents. Each neighbourhood has a registered nurse on each morning shift with four to five care support staff in the morning. There is one registered nurse on each level (i.e., two RNs) in the afternoon with four to five care support staff in each neighbourhood. At night, there are four care support staff and one registered nurse. Vocera badges are held by all staff and staff can locate each other or groups of staff at any time. There is a registered nurse allocated to the dementia unit in the morning.</p> <p>Staff on the days of the audit, were visible and were attending to residents in a timely manner as confirmed by the residents interviewed. Staff interviewed stated that the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed also reported there are adequate staff numbers.</p> <p>Interview with the purchaser confirmed there are no plans to change the roster, staffing policy or skill mix.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrated service integration.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is an implemented organisational admission policy. The resident files sampled had a needs assessment completed prior to entry that identifies the level of care required. The general manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. Once this is confirmed, the resident and/or family arrange to purchase a room on a right to occupy (ORA) contract.</p>

		An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry, including information specific to the memory loss unit. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Registered nurses interviewed could accurately describe the procedure and documentation required for a resident admission in to the facility, and transfer out of, including post-discharge planning and allied health referrals if required. Evidence of these procedures were evident in the resident records sampled, whereby a resident had been transferred to a public hospital acutely due to an infection and had then subsequently re-entered the service at a later date.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. A visit to the resident's room evidenced safe storage. A self-medication assessment had been undertaken and signed by both the registered nurse and GP. All legislative and policy requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs, medication competent care support staff) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver

		<p>training. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration.</p> <p>The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the electronic medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication rooms. The medication fridge temperatures are monitored daily and were within the acceptable range. A new medication room temperature monitoring system has been put in place. The medication rooms all now have air conditioning units set to 21 degrees Celsius, with the room temperatures being monitored electronically every three hours, and a variance report emailed directly to the general manager daily. All medications including the bulk supply order are checked weekly. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Sixteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP and/or NP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</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 meals at Rawhiti Estate are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, very well equipped and a current approved food control plan. The FCP has been registered under the new company. There is a four-weekly seasonal menu that is reviewed by an external registered dietitian. The chef receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Pureed meals have individual components moulded to resemble their original pre-pureed state. Alternative meals are offered for those residents with dislikes or religious preferences. Two meal choices, plus a vegetarian option are provided as standard. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well</p>

		<p>presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained appropriately. Staff were observed assisting residents with meals in the dining areas and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses.</p> <p>The residents and families interviewed were very complimentary regarding the food service, the variety and choice of meals provided. They can offer feedback on a one-to-one basis, via a food compliment book, at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available, could not provide the level of care or the interested party was unable/unwilling to enter in to a purchase agreement.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Six monthly interRAI assessments and reviews are evident for seven of eight resident files sampled as one resident had been in the service for less than six months.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments, are appropriately completed according to need. For the resident files reviewed, the</p>

		outcomes from assessments and risk assessments are reflected into care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred, with evidence of resident and/or family input in to the care planning process. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the mental health team, dietitian, wound care specialist and speech and language therapist. The care staff interviewed advised that the care plans were detailed and easy to follow. Integration of records and monitoring documents are well managed.</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>	FA	<p>When a resident's condition changes, the RN will initiate a GP/NP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner and nurse practitioner interviewed were complimentary of the standard of nursing, leadership, and care provided.</p> <p>Care staff stated there are more than adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The chef (interviewed) was aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included six skin tears, three chronic ulcers, two cancerous lesions, one post-surgical,</p>

		<p>and three classed as 'other'. Wounds are reviewed weekly by the in-house wound champion nurse and there was evidence of wound nurse specialist involvement in chronic wound management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations. Care plans have been updated as residents' needs change.</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>There are four members of the lifestyle support team who are all qualified diversional therapists. They provide a seven-day programme across all care levels. All hold current first aid certificates.</p> <p>The programme is planned monthly and includes themed cultural events, with a different country being the focus every month. A weekly calendar is delivered to each individual resident and there is electronic access to the lifestyle support team via the 'check in care' tablet situated in every resident room. Residents are able to communicate directly with family members via the tablet, in addition to family members being able to see the activities calendar and events of interest which they are then able to attend with the resident if they wish to do so.</p> <p>Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in communal activities (as observed during audit).</p> <p>A variety of individual and small group activities were observed occurring in the care units at various times throughout the day of audit. Entertainment and outings are scheduled weekly. Community visitors are included in the programme. Residents are assessed, and with family involvement if applicable, and likes, dislikes, and hobbies are discussed.</p> <p>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment and outings. Activities include gardening, flower arrangement, baking, cooking, pet therapy hand massage and there is an in-house aromatherapist who holds regular sessions for those residents expressing an interest.</p>

		<p>A separate activity calendar is available for the memory loss unit with activities specifically adapted to the differing level of cognitive ability within the unit. Activities designed to stimulate cognitive and sensory function were observed within the memory loss unit during audit.</p> <p>Resident meetings are held monthly, and family are invited to attend. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents and family members interviewed spoke positively about the activity programme provided.</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 organisation's policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Seven long-term care files sampled of permanent residents contained written evaluations completed six-monthly (as one rest home resident had been in the service for less than six months). Family are invited to attend review meetings (correspondence noted in files reviewed). The GP and/or NP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p> <p>Short-term care plans are 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, 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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurses interviewed could describe the procedure for when a resident's condition changes acutely, and more specialist input and support are required. Discussion with the clinical</p>

		manager, clinical coordinator, and registered nurses identifies that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
<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 regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</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>The building holds a building warrant of fitness which expires 3 May 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, the next checks being due February 2024. Items of medical equipment are calibrated annually and are next due to be checked February 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range.</p> <p>The building has three levels with stairs and elevators between the floors with swipe fob access to independent living areas. All elevators are large enough to accommodate a bed/ambulance stretcher if required. The three levels have direct access to the outdoors due the natural slope of the site. The external areas are well maintained and have attractive features, including wheelchair friendly garden beds and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p> <p>The 20-bed memory loss neighbourhood on level two, opens out into secured outdoor raised gardens, shaded seating and safe walking pathways.</p> <p>Flooring is safe and appropriate for residential care. All corridors have</p>

		sufficient room in order to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.
<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>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. All rooms have a full ensuite; in addition there are adequate numbers of communal toilets in each wing, located near to communal areas. Privacy is assured with the use of ensuite facilities and communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</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 rooms are single with lounge/seating area in addition to the bedroom. There is adequate room to safely manoeuvre mobility aids and transferring equipment in the resident rooms. Resident rooms have external windows allowing adequate light and ventilation. Each room is fitted with call points that link to the Vocera nurse call system and residents have call bell pendants.</p> <p>In the memory loss neighbourhood (dementia unit), bedroom doors are painted in different colours with photo boxes for easier identification of their room. The bedrooms have motion sensors that alert staff to resident movement through the Vocera system.</p> <p>Each apartment has two bedrooms and large enough for a couple.</p> <p>Residents and families are encouraged to personalise their rooms. This was evident on audit, with resident rooms being highly individual and personalised in terms of furnishings and decor.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	FA	<p>There are large and small communal areas, with a dining area on each floor. The dining areas are modern, inviting and appropriate for the</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>needs of the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The facility centres around the central atrium, a large communal space utilised for dining, entertainment, activities and meetings. Residents interviewed commented about the light, airy feel of the atrium and great acoustics for concerts and other resident entertainment held there. All lounge/dining areas are accessible and accommodate the equipment required for residents. Residents are able to move freely and safely, and furniture is arranged to facilitate this.</p> <p>There is also a cinema area, swimming pool and gymnasium available on the lower floor for resident use.</p> <p>The memory loss neighbourhood (dementia unit) is spacious and provides an internal walking area, large communal lounge/dining, well-equipped kitchen and outdoor gardens and grounds. There is a TV lounge, and games lounge with access and entry to the outdoors. There is also a quiet lounge where residents and families can have one-on-one time.</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>There are designated cleaning staff seven days a week. Cleaning trolleys are well equipped and kept in locked areas when not in use. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system.</p> <p>All personal clothing and linen are laundered off site at a commercial laundry. All resident clothing is fitted with an RFID tag to ensure it is returned to the correct resident. Dirty laundry is transported by trolley to the service area where it is collected. Clean laundry is delivered to each area in sealed trolleys, where staff can then deliver items to individual residents. There was sufficient clean linen available on the day of audit.</p> <p>There is a small domestic laundry in the memory loss neighbourhood for family/support staff to use. The food services laundry is washed on site in a designated laundry located in the basement area.</p> <p>Sluice rooms were well equipped and had appropriate PPE available for staff use.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months and there is a New Zealand Fire Service approved evacuation scheme. A large extractor fan is installed in the atrium ceiling as part of the fire evacuation plan.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including water, food and supplies (torches, radio and batteries), emergency power and a gas BBQ is available on the premises as an alternate cooking source. The facility keeps sufficient emergency water for three litres per person, per day for at least three days for resident use on site. A 25,000-litre water tank in the basement can pump water (by the diesel generator) for essential services.</p> <p>There is emergency lighting, and the facility has its own generator in case of power failure.</p> <p>There is a call bell system in all resident rooms, each ensuite and communal areas that has a regular alert, emergency call and nurse presence. The call bell is soundless and has no light indicators. All nurse call activations are transmitted to the Vocera pendant worn by all staff. The pendant can be voice operated, locate staff, make calls and programme reminders as demonstrated on the day of audit.</p> <p>There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>Security policies and procedures are documented and implemented by staff. The buildings are secure at night and the double automatic doors at the main entrance are programmed to open and lock at set times. There is an entrance phone used to call staff who can view the door entrance then programme the entry code using their mobile phone. There are CCTV cameras strategically placed around the complex that</p>

		operate on movement and recorded from the control room.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All resident rooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager fulfils the role of infection control coordinator (ICC) and responsibility for infection control is described in the job description which was evidenced on the day of audit. The ICC oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed externally by a consultant who produces benchmarking which is shared between her client base. The consultant is also available for direction and advice via email and telephone. The ICC, clinical coordinator and general manager meet regularly to discuss the programme as part of the infection control strategy.</p> <p>The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures and service readiness. Staff and residents have commenced Covid vaccinations.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year.</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	There are adequate resources to implement the infection control programme at Rawhiti Estate. The infection control coordinator liaises with the clinical coordinator and general manager in addition to information being shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed annual training

		<p>in infection control through an online learning portal.</p> <p>External resources and support are available through a contracted consultant, external specialists, microbiologist, GP, NP, wound nurse and DHB when required. The GP and NP monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team with external consultant oversight.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a contracted consultant and made site specific by the general manager with input from the DHB infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating education and ensuring staff complete the online training available on the 'Altura' internet-based education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Rawhiti Estate infection control manual. Effective monitoring is the responsibility of the infection control coordinator (clinical manager). An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections is entered onto</p>

		<p>a monthly infection summary in an electronic system (HCSL), which collates the data and facilitates trend analysis.</p> <p>The infection control coordinator provides infection control data, trends and relevant information to the general manager and care staff. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly. If there is an emergent issue, it is acted upon in a timely manner. On review of the surveillance data the infection rate continues to be very low at the facility and there have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS8134.2.</p> <p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using either restraint or an enabler. Staff interviews, and staff records evidenced guidance had been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. The clinical nurse manager is the designated restraint coordinator and is responsible for monitoring any potential use of restraint or enablers.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.