

Fairview Care Limited - Fairview Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Fairview Care Limited
Premises audited:	Fairview Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 July 2021 End date: 29 July 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	47

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Fairview Care Limited (Fairview Care) provides rest home and hospital level care for up to 47 residents. The service is operated by Premiere Lifestyle Limited and day to day operations are overseen by a care manager (CM) and clinical lead nurse (CLN).

There have been no significant changes within the services since the previous surveillance audit in April 2019.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included a pre audit review of policies and procedures, review of residents' and staff files, observations and interviews with the residents, family members, a general practitioner (GP), two external allied health care providers, the chief executive officer (CEO) management, clinical and allied staff. Additional attention was paid to the documentation and detailing of incident reports and progress notes, subsequent to a complaint investigation by the Office of the Health and Disability Commission (HDC) in 2019.

Residents, families and allied health care providers spoke positively about the service and the level of care provided

No areas for improvement were identified during this audit. Success with communication and best practice initiatives has resulted in rating of continuous improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

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

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required although there were no residents on site who did not speak English. Staff provide residents and families with the information they need to make informed choices and give consent.

There are processes in place for residents who identify as Māori to ensure their needs are met in a manner that respects their cultural values and beliefs. Likewise, the needs of people from other cultures are taken into account. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.

Residents at Fairview Care receive services in a competent and timely manner. Assessments and care plans are completed and evaluated by the registered nurses (RNs). All these were current and up to date. Interventions are adequate to meet the residents' assessed needs.

The planned activities provided are appropriate to meet the needs, age, culture, and setting of the service. The activities reflect the ordinary patterns of life and include the involvement of other representatives and other community groups. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a medication management policy in place. The organisation uses a pre-packaged medication system and electronic system in e-prescribing, dispensing, and administration of medications. Staff involved in medication administration are assessed as competent. Medication reviews are completed by the general practitioners (GPs) in a timely manner.

The food service provides and caters to residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical and medical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There have been no restraints for over three years and there were six enablers in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Comprehensive assessment, approval and monitoring process with regular reviews of enabler use occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and are carried out as specified in the infection control programme.

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	1	44	0	0	0	0	0
Criteria	1	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Fairview Care has policies and procedures to meet its obligations as defined in the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The last training was conducted on 18 February 2021. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>All staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by competent residents or the enduring power of attorney (EPOA). The GPs make a clinically based decision on resuscitation authorisation of residents deemed not competent. Sampled files evidenced signed resuscitation decisions and advance directives by residents who are deemed competent. The CLN and SRN reported that residents were informed about advance directives from admission, reminded on an ongoing basis and most residents were reluctant to complete the process.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the</p>

		service actively involves them in decisions that affect their family members' lives. Training on informed consent and EPOA was conducted on 18 February 2021 and staff were conversant with the process.
<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>Policies and procedures require that residents be informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed confirmed that they understand these rights and their entitlement to have the support person of their choice available if they choose. The residents were provided with training on Advocacy services and the Code this year and evidence of this was sighted.</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 were assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends were encouraged to visit or call. The facility has unrestricted visiting hours (unless restrictions are required due to the current Covid-19 pandemic national alert level). Family members interviewed stated they felt welcome when they visited and were comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register contained two complaints received since the previous audit. One of these was investigated by the Office of the Health and Disability Commissioner and the DHB in 2020. There was detailed documentation related to the actions taken subsequent to this event. These showed a range of improvements having been made which are reported in standard 1.2.4. The care manager is responsible for complaints management and follow up and keeps the executive management team and board informed about complaints received. All staff interviewed demonstrated a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Policies are in place to guide staff actions and ensure residents' rights are discussed. The Code was displayed throughout the facility and is available in Te reo Māori and English languages. Information about the Code is provided in the admission pack and included in the resident agreement. Family</p>

<p>Consumers are informed of their rights.</p>		<p>members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process. The Nationwide Health and Disability Advocacy Service poster and pamphlets were also displayed. Residents' agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff was observed maintaining privacy. A contracted physiotherapist (PT) visits every Tuesday for four hours to conduct the physiotherapy programme with help from the staff. The PT reported that residents were assessed on admission, post-fall, and on an ongoing basis. Residents are supported to maintain their independence during the provision of activities of daily living and engaging in active exercises. Residents from the rest home and hospital areas were able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The required policies on cultural appropriateness were documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs. There was one resident who identified as Maori, and the person's cultural needs were addressed in the care plan. In the interview conducted, the family/whānau and resident confirmed that all their cultural needs were met. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff received cultural training annually and the last training was conducted on 11 May 2021.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>Family members were interviewed to confirm that the resident's values and beliefs are actively recognised and well supported. This was confirmed by residents and through observations of interactions between staff and residents during the audit. Values and beliefs were discussed and incorporated into the care plan. The family members interviewed gave examples of being actively</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		involved in any changes in routine for their relative. Staff interviewed were able to describe how each resident can make choices around activities of daily living and activities. Residents on the days of the audit were observed to actively engage in activities of their choice.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Fairview Care has a policy on discrimination in place. This includes guidelines for staff regarding the prevention, identification, and management of discrimination, harassment, and exploitation. The clinical lead nurse (CLN) and the senior registered nurse (SRN) reported that the rights of the individuals were protected, and interventions occur to ensure a balance between the personal rights of the individual and others living and working in the facility. All family members interviewed reported that they believed their family members were always safe. Staff receives training on professional boundaries and the Code of Conduct. The Code of Conduct is embedded in the employment agreement and is signed by each staff member on entry to the service. Situations that constitute misconduct are included in staff employment agreements.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service encourages and promotes good practice through the ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The GP confirmed promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their professional networks to support contemporary good practice. Care staff has either level one, two, three, and four New Zealand Qualification Authority (NZQA) qualifications and while others were considering enrolling. All family members interviewed stated that each resident received good care and support with staff conscious of managing all residents' identified needs effectively. A continuous improvement rating was awarded, relating to the project Scheduled Intentional Rounding (SIR) which was initiated following complaint. The results were evident in the satisfaction surveys completed and interviews conducted with residents, staff, and family member representatives.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive	FA	There was evidence that the service adheres to the practice of open disclosure. Access to interpreter services is available through the district health board if required. At the time of the audit, there were no residents who required an interpreter. Staff was observed to engage with residents in a way that involves them as much as possible. Staff can provide interpretation as and when needed and the use

to effective communication.		of family members and communication cards when required is encouraged.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The 2021 business plan contains clearly described goals with specific measures and timeframes. These goals are monitored for progress via the CM's monthly reports to the CEO who reports to the board of directors. A sample of these reports and minutes of the three monthly managers meetings, confirmed that organisational performance in areas such as staffing, emerging risks, occupancy and financial matters is monitored and reported on.</p> <p>The organisations mission, values, scope and direction are articulated in service literature, on the company website and are on display in the building. Interview with the CEO of the company who has been in the role for six years, confirmed there was effective and efficient governance with the directors being kept fully informed about matters impacting the care facility and the two retirement villages. A large percentage of referrals into Fairview Care are from the retirement villages. Occupancy has been maintained at 98% for the last two years.</p> <p>All service delivery in the care facility is overseen by a care manager who is an RN with many years of experience in the New Zealand aged care sector. This person has been in the role for three years and was previously employed at Fairview Care as the clinical lead nurse for four years. Responsibilities and accountabilities are defined in a job description and in the individual employment agreement. The CM demonstrated knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at national conferences, DHB forums (via zoom) and online education. The CM is maintaining their annual practising certificate (APC) and current first aid certificate.</p> <p>The CM is supported by a full time employed Clinical Lead Nurse (CLN). The CLN had been working at the facility for over three years and recently stepped into the role of clinical lead. The previous clinical nurse lead continues to work at Fairview and actively participated in this audit.</p> <p>The service has an aged residential care contract (ARCC) with Waitemata DHB for the provision of hospital and rest home level care, short term/ respite, and palliative care to a maximum of 47 residents. Each of the 47 bedrooms are approved for dual use (hospital or rest home care).</p> <p>On the days of this audit there were 47 residents on site. These included five residents assessed as requiring rest home level care and 42 residents requiring hospital level care. There were no people under the age of 65 years. Three newly admitted residents were waiting for needs assessment and service coordination (NASC) from the external assessors. Wait time for this was reported to be around 10 weeks.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the care manager is absent, the clinical lead nurse shares the role with the administrator who both carry out the required duties under delegated authority.</p> <p>During absences of the clinical lead nurse, all clinical matters are overseen by the care manager with on the floor support from senior RNs. The CM who was previously the clinical lead nurse, understands the role and is competent to manage any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. Aspects of the system includes data from incidents and complaints, outcomes from internal audits, restraint and infection events, wounds and pressure injuries.</p> <p>Interviews and documents sighted revealed regular review and analysis of quality data and related information is reported and discussed regularly at management and staff meetings. Quality, risk and quality data findings are reported to and discussed monthly at the recently established quality meetings and at the registered nurse meetings.</p> <p>Staff reported their involvement in quality and risk management activities through being members of specific committees such as infection control, falls, nutrition and restraint as well as undertaking audit activities, and implementation of corrective actions. There was documented evidence of corrective action plans having been developed and implemented to address any shortfalls. (Refer to standard 1.1.9 for improvement initiatives)</p> <p>Regular resident meetings are held where residents are asked if they have any issues or concerns. The service completes a six-week post-admission survey for all residents where family input is included. Any issues that arise from these individual surveys or resident meetings are addressed accordingly using the corrective action process. The last resident and family satisfaction survey was undertaken in April 2021. Feedback from these was positive, with food services identified as requiring more focus on meeting the individual preferences of some residents. The CM continues to address this with food services staff.</p> <p>The policy system is specific to the age care sector and moderated by the external consultant who developed and reviews the system continuously. These policies reviewed prior to the audit, 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 were based on evidence-based practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p>

		Both the CM and the CLN described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. An up-to-date risk register is available to all staff. There have been no staff injuries requiring notification to Worksafe since the previous audit.
<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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were completed with sufficient detail about the event, and that families or significant others had been notified in a timely way. There was evidence that information about the event was entered into the resident's progress notes, to alert all other staff and to provide a historical record. Adverse event data is collated, analysed for trends and reported to the quality committee, the RN meetings and general staff meetings.</p> <p>A falls event in 2020 led to a complaint investigation by the Office of the Health and Disability Commissioner and the DHB. Recommendations made by the DHB and HDC have been fully implemented to good effect as evidenced by the documentation of actions taken subsequent to the event occurring. Examples of these improvements are the implementation of 'schedule intentional rounding' (SIR) each hour and a colour sticker display system that provides staff with an up to the minute, quick and easy reference to the type of events and times they occurred. Although intentional rounding and the colour sticker system has not, as anticipated, reduced the number of events occurring, residents reported that they feel less lonely and staff described being more aware of the likely times a fall, bruise, skin tear, or behavioural concern may occur. The outcomes from these initiatives are recognised in standard 1.1.8.</p> <p>Other corrective actions implemented as a result of the HDC and DHB investigation are staff training on incident reporting and subsequent monitoring of incident reports to ensure they contained sufficient details.</p> <p>The CM and other senior staff understood the requirements for essential notification reporting. They advised there have been no notifications of significant events made to the Ministry of Health, or DHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and performance reviews after an 11-week period and annual staff appraisals were up to date.</p> <p>In service and other staff education is planned on an annual basis, including mandatory training requirements. A spreadsheet allows the CM to track and monitor all staff attendance at education sessions and their ongoing professional development.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 23 health care assistants employed, nine have achieved level 3 of the National Certificate in Health and Wellness and are progressing Level 4, four HCAs have completed level 2 and 10 are yet to commence the programme. A senior RN is the internal assessor for the programme.</p> <p>Of the 11 RNs employed (including the CLN and the CM) eight are trained and maintaining their annual competency requirements to undertake interRAI assessments. The CM has management access to interRAI.</p> <p>All the RNs are competent with syringe drivers and the clinical leaders are managing peg feeds and PICC lines for palliative care residents.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7).</p> <p>The CM adjusts staffing levels to meet the changing needs of residents. The CLN and CM are on call afterhours and staff reported that immediate access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There has been no use of bureau staff for more than a year. At least one staff member on duty has a current first aid certificate.</p> <p>There are two RNs and eight HCAs on each morning shift plus the RN care manager and clinical lead nurse from Monday to Friday. Six of the morning shift HCAs work from 7am to 3pm and two work from 7am to 1pm.</p> <p>The afternoon shift roster has two RNS and six HCAs- two of these work from 3pm to 11pm, three from 3pm to 10pm and one HCA from 3pm to 9pm.</p>

		<p>Night shifts are staffed by one RN and two HCAs.</p> <p>This provides a staff/resident ratio of 1:4.5. The CM and staff interviewed said an additional HCA is rostered on to each shift if a resident is unsettled and requires 1:1 supervision.</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>	FA	<p>Residents' records are held both electronically and paper based. The staff have individual passwords to the residents' records database, such as the medication, record management system, and the interRAI assessment tool. The visiting GPs and allied health providers also have access to the system which supports the integration of residents' records.</p> <p>All hard copies are kept securely in the locked cupboards and archive room. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.</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>	FA	<p>Fairview Care's entry to service policy includes all the required aspects on the management of inquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice where appropriate, local communities, and referral agencies. Needs Assessment and Service Coordination (NASC) authorisation forms confirming the appropriate level of care were sighted in residents' files sampled.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The family/whānau interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort/family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service uses the DHB's ('yellow envelope') system to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service has a safe electronic medication management system in place that was observed on the day of the audit. The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and meets legislative requirements. All staff who administer medicines are competent to perform the function they manage. Current medication administration competency forms were sighted.</p> <p>The RNs who were observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley in the nurses' station. The staff has individual passwords to access the electronic medication management system. The medicine fridge and medication room temperatures were monitored, and the reviewed records were within the recommended ranges.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Medication reconciliation is conducted by the RNs when the resident is transferred back to the service from the hospital or any external appointments. All medications sighted were within current use-by dates. Pharmacist input is provided on request. All expired medications were returned to the pharmacy in a timely manner. All eye drops were dated when opened. Controlled drugs are stored securely following requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The GPs completed three-monthly medication reviews consistently, this was verified on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed consistently.</p> <p>There was one resident who was self-administering medication at the time of the audit. Appropriate processes were in place to ensure this was managed safely. Interviewed staff demonstrated awareness of the medication self-administration process.</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 kitchen service complies with current food safety legislation and guidelines. The food service is managed by the food services manager supported by the chefs and catering assistants. There is an approved food control plan for the service which expires 8 June 2022. Meal services are prepared on-site and served in the respective dining areas. The menu has been reviewed by a registered dietitian. The kitchen staff have current food handling certificates.</p> <p>Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents' weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and</p>

		<p>drinks are available for residents throughout the day and night when required.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained. Food is transported in a hot cart box to the respective dining areas.</p> <p>The residents and family/whānau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The CLN and SRN reported that all residents who were declined entry were documented. When a resident is declined entry, family/whānau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Residents' level of care is identified through the needs assessment process by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' long-term care plans and interRAI were completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family, residents, and other health team members as appropriate. Additional assessments were completed according to the need (eg, behavioural, nutritional, falls, continence, and skin and pressure risk assessments). The RNs utilise standardized risk assessment tools on admission. In interviews conducted, family member representatives and residents expressed satisfaction with the assessment process.</p>
<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>The outcome findings from interRAI assessments and input from residents and/or family/whānau inform the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident-focused and individualised. Short-term care plans sampled were evaluated weekly and had interventions that were appropriate for the identified problem. Behaviour management plans identifying triggers and interventions were implemented as required. Family and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses,</p>

		physiotherapists, occupational therapists, district nurses, dietitians, speech-language therapists, and GPs.
<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>The interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents' assessed needs and desired outcomes. Observations and interviews verified that care provided to residents was consistent with their needs, goals, and the plan of care. Significant changes were reported in a timely manner and prescribed orders were carried out. Evidence of documented significant changes were sighted through interRAI assessments and short-term care plans. Interventions were detailed to guide staff these included hourly checks of residents by all staff (Refer to 1.1.8.1). Wound assessment and wound care plans were being completed and evidence of this was sighted in files sampled. All residents with weight issues had short-term care plans in place with detailed interventions. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet 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 service.</p>	FA	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by two diversional therapists (DTs) from Monday to Sunday in the two respective wings. There are volunteers from the village who come twice a week to assist with activities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family and residents where required.</p> <p>The activity programme is formulated by the activities staff. The activities are varied and appropriate for residents assessed as requiring rest home, and hospital level of care. Residents' activities care plans were evaluated every six months, progress notes are completed daily or as required, and attendance checklist daily. Activities include brain fitness, nail care, scrabble, cardio drumming, use of smart board, music, happy hour, movies, exercises, bingo, trivia, board games, bus trips, word games, family and friends' visits, group and one on one activities.</p> <p>The service featured on a television programme seven-sharp where they performed a cardio drumming session which most residents like. They also entered the New Zealand Aged Care Association activities competition and are currently a contender. Residents' meetings are completed quarterly, and any concerns are acted upon by the management.</p> <p>Activity plans reflected residents' preferred activities of choice and were evaluated every six months or as necessary. The residents were observed participating in a variety of activities on the audit days.</p>

		The planned activities and community connections were suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members and residents reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans and short-term care plans were evaluated by the RNs in a timely manner. Evaluations sighted were individualised and indicated the residents' degree of response to the interventions and progress towards achieving the desired outcome. Changes were made to the care plans where the desired goal was not met. The interviewed residents and family confirmed their involvement in the evaluation of progress and resulting changes. Interviews verified residents and family members were included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GPs and the nursing team refers to specialist service providers and the DHB. Referrals are followed up regularly by the GPs. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Care staff do not have access to or handle hazardous chemicals. The type of hazardous chemicals on site are garden/horticultural and building maintenance products such as degreasing or mould removing agents. These are only accessible to grounds staff and were seen to be stored securely in a suitable location. Other chemicals and cleaning products are supplied by an external company who visit regularly to manage stocks and provide product t training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Cleaning staff have achieved Level 2 cleaning qualifications. There were ample supplies of protective clothing and equipment available on site and staff were observed using this.

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 21 February 2022) was publicly displayed.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p> <p>There is easy access to flat level decks, grass and gardens via sliding doors in the main lounge and from all bedrooms situated on the north facing side of the building. These external areas inspected were safe, well maintained and furnished appropriately for the resident group.</p> <p>Staff said they knew the processes for requesting repairs or maintenance and that these are followed up and actioned usually on the same day. Residents and family members were happy with the environment</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Each of the 47 bedrooms has a disability accessible bathroom with shower, toilet and vanity. There were additional toilet facilities close to the main lounge plus designated staff and visitors' toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Hot water temperature monitoring of all resident and staff accessible taps is conducted monthly. Temperatures did not exceed 45 degrees Celsius in resident areas or 60 degrees Celsius in the laundry and kitchen servery areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry by a designated laundry staff. This person interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Members of the cleaning team have undertaken the New Zealand Qualifications Authority Certificate in Cleaning (Level 2) as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit programme. There have been no issues with cleaning or laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>There have been no changes to the building since the fire evacuation plan was approved by the Fire and Emergency New Zealand Services (FENZ) at the time the facility was occupied.</p> <p>Six monthly fire drills were occurring, the most recent being in April 2021 with a copy sent to FENZ. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet The National Emergency Management Agency recommendations for the region. There is 35,000 litres of water stored in tanks in the basement and an arrangement with the power supplier to provide a plug in generator in the event of power outage. Emergency lighting is regularly monthly.</p> <p>Call bells alert staff to residents requiring assistance. An observed call bell activation on day two of the audit saw nine staff attend to assist within seconds. Residents and families reported staff respond promptly to call bells and this was also observed throughout the audit.</p> <p>Appropriate security arrangements are in place. Access to the building after hours is by electronic</p>

		fobs. Doors and windows are locked at a predetermined time and external areas are security monitored by television cameras.
<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	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto the outside gardens and patio areas. Heating is provided by electricity and temperatures are individually controlled in residents' rooms. There were heat pumps with air conditioning functions throughout the facility. Areas were warm and well ventilated throughout the audit and residents and families said all areas were maintained at a comfortable temperature.</p> <p>The building and grounds are smoke free, except for one outside area designated for the sole resident who smokes.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, infection prevention, and control audits and policies and procedures. The CLN and another registered nurse co-share the role of the infection control coordinator (ICC) and have access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for both ICCs including roles and responsibilities are in place.</p> <p>Staff is made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. The organisation provides relevant training, there were adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits were completed, the required policies and procedures are documented, and staff are advised not to attend work if they are unwell. Flu and Covid-19 vaccines are offered to all staff and residents.</p> <p>There is a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. COVID-19 pandemic contact tracing measures were implemented. There have been no infection outbreaks reported since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The CLN and RN are responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the 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>		<p>Infection control reports are discussed at management and staff meetings. The ICCs have access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, learning, and training coordinator, and the attending GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all the respective two wings nurses' stations, and these were current. Staff was observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. Education is provided by a suitably qualified infection prevention and control consultant and the ICCs. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained and was sighted in records reviewed. The following training was provided to staff by the service: hand hygiene and personal care; infection prevention and control; dental hygiene; scabies and lice; pandemic outbreak control; donning and doffing of personal protective equipment and regular Covid-19 updates.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance carried out is following the agreed objectives specified in the infection control programme and is appropriate for the size and setting of the service. All identified infections were documented, monthly data was collated and analysed. Monthly reports were completed and presented to the CM, CEO, and board of directors. Recommendations and corrective actions to assist with reducing and preventing infections were acted upon.</p> <p>Short-term care plans were implemented with appropriate interventions to manage the identified infections. New infections and any required management plans were discussed at handover, to ensure</p>

		early intervention occurs. Monthly surveillance results were shared with staff in staff meetings. Comparisons against previous months were conducted to monitor trends and evidence of this was sighted.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities.</p> <p>On the day of audit, six residents were using a bed lever as enablers. This equipment is placed on the side of the bed at shoulder height to assist with positioning in bed. Staff refer to these as bed cradles, they are not restrictive and used voluntarily at the residents request. A comprehensive assessment, signed consent and evidence of regular reviews of the need to continue with the bed cradles was seen in the restraint documentation. Alternatives such as low beds, with sensor mats and fall out mattresses alongside the bed, were in use as alternatives to bed rails.</p> <p>There had been no use of restraint interventions at Fairview Care for more than three years.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The CLN and SRN reported that all adverse events were managed in an open manner, and these were put in the context of quality improvement. This was evident in the incident forms completed and interviews with family members and residents.</p> <p>The service embarked on a quality initiative project following a Health and Disability Commission (HDC) complaint in September 2020. The project was to improve monitoring on residents, improve communication between staff, reduce incidents of falls, reduce the number of call bells, ensure residents are always in a comfortable position, personal needs are met, items of residents are placed within reach, reduce loneliness and for staff to get to know residents better. The project was named Scheduled Intentional Rounding (SIR). The checks were completed hourly, and results were documented. The SIR was completed by all staff and the night shift was responsible for uploading all completed documents on the electronic record management system and new documents set out for the following day. Results of the SIR were discussed in the following meetings, staff, toolbox, care staff, RN, and individual discussions. Several recommendations were made and implemented to</p>	<p>The achievement of the quality improvement project is rated beyond the expected full attainment. With this project, there has been an improved documented review process which includes the analysis and reporting of findings. Results are continuously reported to the staff, management, and board. The SIR project is ongoing, and staff continue to monitor its effectiveness and any enhancements are made as required.</p>

		<p>improve the process.</p> <p>Positive outcomes have been measured in staff, resident, and relative satisfaction surveys conducted. Pictorial evidence was sighted in the documents provided for review. 20% of residents and 70% staff were surveyed and the results of the project were positive. Although there was no reduction in falls, residents and families reported reduced loneliness and improved contact with residents including those who have a cognitive impairment, deteriorating and new residents. Improved communication was between staff in all shifts and increased monitoring of residents 24/7 were noted. This was evidence of good practice by staff in monitoring and meeting all residents' needs in a timely manner. The documented evidence from this project ensured that corrective action plans were developed and implemented to address any shortfalls. This was also confirmed in interviews conducted with the staff, residents, GP, and family/whānau, respectively.</p>	
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End of the report.