

# Dargaville Aged Care Limited - Norfolk Court Home and Hospital

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## 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:

<b>Legal entity:</b>	Dargaville Aged Care Limited		
<b>Premises audited:</b>	Norfolk Court Home and Hospital		
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care		
<b>Dates of audit:</b>	Start date: 23 February 2022	End date: 24 February 2022	
<b>Proposed changes to current services (if any):</b> None.			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> 58			

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Dargaville Aged Care Limited - Norfolk Court Home and Hospital provides rest home, secure dementia, and geriatric hospital care for up to 63 residents. Residents and families spoke very positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, the facility manager/owner, clinical nurse manager, staff and a general practitioner.

No areas requiring improvement were identified. The audit has resulted in one continuous improvement rating in relation to skin integrity management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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The Code of Health and Disability Services Consumer Rights (the Code) is incorporated into the service's policies and procedures, and into everyday practice in the way care and support is provided. Residents who were interviewed advised that they are aware of their rights and can choose what they want to do. They confirmed that there is good communication from staff.

Residents are treated with dignity, respect, and understanding. Privacy is respected and ongoing family involvement is encouraged. Cultural and spiritual values, beliefs, and wishes are identified and supported. There is ongoing contact with the local health and disability service advocate.

Residents can participate in a range of activities, both within the service and in the wider community. They are supported and encouraged to be as independent as possible.

There was no evidence of abuse or neglect, or any discrimination, coercion, harassment, sexual, financial, or other exploitation.

Complaints are reported, investigated and responded to in a timely manner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The facility manager is the owner and actively works in the care home. The facility manager is experienced and suitably qualified and is supported by a clinical nurse manager.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service to establish the level of care. The nursing team is responsible for assessment, planning and provision of care, evaluation, and exit from the service. InterRAI assessments and care plans are completed in a timely manner.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity plans are in place.

There is a medicine management system in place. The general practitioner (GP) is responsible for three monthly medication reviews. Staff involved in medication administration are assessed as competent to do so.

The food service provides and caters to residents' nutritional needs. Specific dietary likes and dislikes are accommodated. A food control plan was in place. 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.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. The facility meets the needs of residents and was clean and well maintained. An extensive renovation and refurbishment programme has been in progress with staff, residents and family members noting this as a positive change. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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.

The organisation has policies and procedures that support restraint minimisation. Twelve residents had restraints in use at the time of audit. Staff discussed the recent purchase of new equipment aimed at reducing the use of restraint. A process of restraint related assessment, approval, monitoring and regular review occurs.

One resident was using an enabler. Use of enablers is voluntary for the safety of residents in response to individual requests.

Staff were able to details their responsibilities when caring for residents with restraints and enablers in use.

## 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 (ICC) 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)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	1	100	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and the annual in-service education programme. Annual training on the Code was last conducted on 13 December 2021. Staff were observed on the days of the audit to demonstrate knowledge of the Code when interacting with residents. For example, staff was observed knocking on residents' doors before entering their rooms, staff spoke to residents with respect and dignity, calling residents by their preferred names.  The residents interviewed confirmed that they are treated with respect and understood their rights. The whānau reported that residents are treated with respect and dignity.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	Nursing and care 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 the enduring power of attorney (EPOA), where applicable. Residents in the dementia wing had enacted EPOA and one had Protection of Personal and Property Rights (PPP). The GP makes a clinically based decision on resuscitation authorisation.  There are guidelines in the policy for advance directives that meet legislative requirements. Advance

choices and give informed consent.		<p>directives and advance care plans are used to enable residents to choose and make decisions related to end-of-life care. Some files reviewed had signed advance care plans that identify residents' wishes and meet legislative requirements.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</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>As part of the admission process residents and their whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the Nationwide Advocacy Service were displayed and available in the facility. Residents and whānau were aware of the advocacy service, how to access this, and their right to have support persons. The CNM and staff provided examples of the involvement of advocacy services concerning residents' care.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their whānau and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. All residents are assisted in accessing community resources and mainstream support. Whānau and friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' whānau and friends. Restrictions are put in place in response to Ministry of Health COVID-19 protocols. Whānau members interviewed stated they felt welcome when they visited and 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/concerns 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 complaint forms are available in the main entrance. Residents and relatives interviewed said they had been informed about how to raise concerns or complaints.</p> <p>The complaints register reviewed showed that six written or verbal complaints have been received since 20 May 2021 and included one complaint received via the DHB in May 2021. Each of these had been acknowledged and investigated by the facility manager who is responsible for complaints management. Interview with the facility manager and review of the notes confirmed that each matter had been fully investigated, that all parties were kept informed and that appropriate actions were taken to achieve resolution. The complaint via the DHB was not substantiated, however several other recommendations were agreed, and these have been implemented.</p>

		<p>The care staff interviewed demonstrated understanding about the complaint process. There have been no complaints received from the Office of the Health and Disability Commissioner or the Ministry of Health since the last audit.</p> <p>The facility manager has an 'open door' policy and family were observed presenting to speak to the facility manager or the CNM during audit. All residents and family spoke very positively about the manager's approach, responsiveness to questions or concerns and the ongoing processes that have been occurring to improve the care home environment.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their whānau, as confirmed in an interview with the clinical nurse manager (CNM). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally during daily care. Education is held by the Nationwide Health and Disability Advocacy Service annually. In interview conducted, residents and family/whanau reported that they were informed of their rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policy and procedures regarding resident safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. 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>There were no documented incidents of abuse and neglect reported since the last audit. Whānau and residents interviewed expressed no concerns regarding neglect or culturally unsafe practice.</p> <p>Staff attended training on privacy on 22 November 2021 and evidence of this was sighted in files reviewed. Residents' privacy and dignity are respected. Staff were observed maintaining privacy.</p> <p>Residents are supported to maintain their independence. There is a contracted physiotherapist who visits the service weekly if required following resident referral.</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>Norfolk Court acknowledges its responsibilities in its current operations to Māori residents. The CNM confirmed that the service responds in accordance with the Treaty of Waitangi taking into consideration the Māori Health Strategy and the Māori Health Plan. Assessments and care plans document any cultural and spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required.</p> <p>Cultural staff training is incorporated into the staff annual in-service education calendar. Six residents identified as Māori and there were five staff members of Māori descent. Policies and procedures regarding the recognition of Māori values and beliefs are documented.</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>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following protocols/guidelines as recognised by the resident and their whānau. Values and beliefs are discussed and incorporated into the care plan. Whānau and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in the care plans reviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Whānau interviewed stated that residents were free from any type of discrimination, harassment, or exploitation and that they felt safe. Residents interviewed reiterated the same. The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CNM stated that there have been no incidents of abuse or episodes of neglect, nor discrimination towards residents reported.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The service encourages and promotes good practice through evidence-based policies and input from external specialist services and allied health professionals, for example, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their</p>

		<p>professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents' safely. Most care staff have either level one, two, three, or four New Zealand Qualification Authority (NZQA) certificates. Further training is conducted online, and records were sighted.</p> <p>The activities programme evidenced good practice for residents assessed as requiring the types of care provided.</p> <p>A continuous improvement rating was awarded in relation to management of residents with impaired skin integrity.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Whānau members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which are supported by policies and procedures. Personal, health and medical information are collected to facilitate the effective care of residents.</p> <p>The CNM reported that a variety of external resources, including support groups and interpreter/translation services, are accessed as required. The staff further reiterated that residents and relatives who are not conversant with the English language are advised of the availability of interpreter services at the first point of contact. There were no residents who required the services of an interpreter; however, the staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business plan (2021-2022), which is reviewed annually, and other documents including the quality and risk plan, outline the purpose, values, scope, direction and goals, of the organisation. The documents described annual and longer term objectives and other associated operational plans. These predominantly related to making improvements in the facility and purchase of new equipment, linen and furniture. These plans were developed by the facility manager who is also the sole director of the care home. The facility manager monitors operational performance on an ongoing basis, and progress towards achieving the goals. The facility manager was aware of all incidents, accidents, complaints/concerns, as well as the results of internal audits and survey results.</p> <p>The facility manager purchased Norfolk Court Care Home and Hospital (Norfolk) on 12 May 2021. The facility manager trained as a registered nurse overseas, however, does not have a New Zealand annual practising certificate, but is looking to progress New Zealand registration in response to a recent government initiative being announced. The facility manager has worked in aged related residential care</p>

		<p>(ARRC) facilities in New Zealand for over 14 years, initially as a caregiver then moved into management roles. The facility manager previously had part ownership of an ARRC facility in Auckland and worked in the care home on a day to day basis as the facility manager for five years. The facility manager keeps current with developments in the sector and has attended more than eight hours of education in the last 12 months as required to meet the provider's contract with Northland District Health Board (NDHB). The facility manager works full time in the care home and is on site daily weekdays and most weekends and is on call when not on site.</p> <p>The facility manager is supported by the clinical nurse manager (CNM), a registered nurse, who works full time at Norfolk. The CNM trained overseas and has worked as a nurse for 25 years in various roles including as a lecturer. The CNM has worked at Norfolk Court Rest Home for 12 months as a registered nurse before being appointed to the CNM role in 2021 (prior to the current owners purchase of the care home).</p> <p>A clinical manager works RN morning shifts weekdays in the secure dementia unit and is responsible for coordinating resident care in this unit. The clinical manager is also responsible for infection prevention and control activities.</p> <p>The service has Aged Related Residential Care (ARRC) contracts with the DHB for hospital, rest home (including dementia care), long term support-chronic health conditions (LTS-CHC) and residential respite care. There is one bed that is solely utilised for the provision of respite care with NDHB, with residents booked for a two week stay.</p> <p>On the days of audit, 58 people were receiving services. This comprised 27 hospital care residents (including one respite resident), 16 rest home level of care, and 15 residents receiving secure dementia care. There were no residents under the LTS-CHC contract. The care home is certified to provide care to 63 residents. However, this would require twin occupancy rooms to be used. The facility manager advised there is currently one husband and wife in the same room. The other five rooms that could have two residents are being used by one resident, so at present the care home is considered fully occupied. Thirty five rooms in the rest home and hospital could be used by either rest home or hospital level care residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner</p>	FA	<p>When the facility manager is absent, the clinical nurse manager (CNM) is responsible for oversight of services provided. The CNM was aware of what this entailed and who to contact if other specific business related information was required. The management team noted these arrangements worked well.</p>

which ensures the provision of timely, appropriate, and safe services to consumers.		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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 system that reflects the principles of continuous quality improvement. This includes the reporting and management of accidents and incidents, complaints, restraint and infections. Internal audits, and resident and relative satisfaction surveys, are conducted regularly to measure performance. Template audit tools are used. Outcomes from all these activities are reported and any actions required are implemented and monitored for effectiveness. A review of at least eight audits demonstrated that there is a high level of compliance with organisation policy.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality data and that related information is reported and discussed at the monthly registered nurses (RN) meetings, residents meetings, and the staff meetings which also included health and safety and infection control matters.</p> <p>Staff reported their involvement in quality and risk management activities through participation on committees, discussion at staff handover or at meetings, incident and hazard reporting and via internal audit activities.</p> <p>There was a good response to the most recent resident and family satisfaction survey (October 2021) which revealed a high level of satisfaction and minor matters that were investigated and addressed.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an external consultant and provide to the facility manager for review. The documents are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The facility manager is responsible for document control. A paper copy of all policies is available for staff.</p> <p>The facility manager 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. The risk register was last reviewed in January 2022, the hazard register is current, and a hazardous substance register is also in place.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or</p>	FA	<p>Staff document adverse and near miss events on an incident/accident form. This is provided to the RN on duty for review and immediate follow-up, then provided to the CNM for further review and monthly analysis / trending. The analysis of incidents for residents in the rest home and hospital is separate to that of residents in the secure dementia unit. Analysis included monitoring the time of day incidents occurred and</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>the location.</p> <p>A sample of incidents forms reviewed showed that these were fully completed. The sample included a staff injury (burn), challenges with family non-compliance to Covid-19 restrictions, falls (with and without injury), refusal of medicines, a bruise, skin tear and a pressure injury. Incidents were investigated and immediate actions taken to address the issues. Short term care plans were developed for applicable events. Adverse event data is collated, analysed and discussed at the staff meeting. Family members interviewed confirmed they are informed of all events including those they considered of a 'trivial' nature.</p> <p>The facility manager and CNM described essential notification reporting requirements, including for pressure injuries. There have been three Section 31 notifications made since the last audit. These related to the DHB complaint, an event requiring police assistance, and a fire that occurred in the laundry.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The facility manager is no longer able to access the results of all police vetting records undertaken under the previous owner's access log-in. However, has a new account log-in, for police vetting of new staff as they are employed. This process was sighted.</p> <p>All registered and employed staff have a current annual practising certificate, where this is applicable.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared for their role and responsibilities. Staff records reviewed showed documentation of completed orientation and a review after a three-month period. A newer staff member confirmed that their orientation suitably prepared them for their role and responsibilities.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements scheduled over the year. Education included online learning with specified topics scheduled each month. A designated staff member monitors attendance, and the accuracy rates of staff response to the associate quiz and summarises this. Where staff have not obtained a satisfactory result, the module is to be repeated. A key focus of training has been to get as many staff as possible to complete the required modules to obtain an industry approved qualification in dementia care. This is part of the Covid-19 risk preparation to ensure there are sufficient qualified staff that can work in the secure dementia unit if the usual staff are unable to for any reason. Thirty four staff have completed the modules. The staff that have not completed this have been employed less than 18 months. The facility manager is waiting the certificates of completion to be provided. Staff were very complementary about the quality of education provided and the support they receive to study and achieve. Residents and relatives spoke highly about</p>



		<p>the professionalism and competency of all staff they encounter.</p> <p>Fifteen staff have a level one industry approved qualification, six staff have a level two, two staff have a level three qualification and four staff have a level four industry approved qualification in health and wellbeing.</p> <p>There are sufficient trained and competent registered nurses (five RNs and the clinical nurse manager), who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Staff responsible for medicine administration have current competency. This includes seven nurses with syringe driver medicine competency, three RNs have phlebotomy competency and there are 23 staff who have competency as a second checker of medicines.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were sufficient staff available to complete the work allocated to them and that the system in place to replace absenteeism now works well. Residents and family interviewed supported this. Staff advise there is a culture of teamwork and staff work together to ensure the care needs of residents are met. A number of staff have been trained to complete requirements of several different positions to give the facility manager more flexibility in the event of staff shortages due to Covid-19 restrictions. The facility manager has also worked as a carer when required and has completed food safety training.</p> <p>Observations and review of four weeks of the roster confirmed adequate staff cover has been provided. Staff are rostered to work in designated units, with at least one staff member in the dementia unit at all times. There is a minimum of three carers and one registered nurse on duty overnight. There are sufficient administration, cleaning, laundry, kitchen and maintenance staff rostered.</p> <p>Activities are offered in the rest home/hospital weekdays for six hours per day, and on weekends for special events, and from 10 am to 2 pm in the secure dementia unit daily.</p> <p>Twenty four staff and managers are maintaining current first aid certificates with CPR including all the RNs so there is always at least one staff member on duty with this. There is at least one RN on duty in the hospital every shift, and an RN works in the secure dementia unit (15 residents) on morning shifts (including weekends), and some afternoon shifts as RN staffing permits. The facility manager advised there are current vacancies for part time kitchen assistants, and a registered nurse position is being</p>

		<p>recruited as an 'extra'.</p> <p>The GP visits each Tuesday and there is a GP from the local practice on call at all times. A new podiatrist has recently been contracted. A dietitian is available and undertakes telephone consultations where required. Pharmacy services are provided by the local pharmacy. Other allied staff are sought from the DHB on a referrals basis if clinically indicated.</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>A resident register of all current and past residents is maintained. The residents' individual information is kept electronically and paper-based. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review.</p> <p>Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful inquiries are referred to their referrer for alternative providers that may suit their needs. Clinical notes were current and integrated with the GP, podiatrist, physiotherapist, pharmacists, and other allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in a 'Cloud-based' system. Residents' files are held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit.</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>The entry to service policy includes all the required aspects for 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 whānau members of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for the dementia unit, rest home, and hospital level of care residents were sighted.</p> <p>Residents in the dementia unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed the current level of care.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. 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>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation.</p> <p>Indications for use are noted for pro re nata (PRN) medications, allergies are indicated, and photos of residents were current. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription, and these were updated every fortnight or when there were any medication changes. The GP completes three monthly reviews.</p> <p>Medication competencies were completed annually for all staff administering medication.</p> <p>There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner. Monitoring of the medicine fridge and medication room temperatures are conducted regularly and deviations from normal were reported and attended to promptly. Records of this were sighted.</p> <p>The RNs were observed administering medications safely and correctly in their respective wings. Medications were stored safely and securely in the trolley and locked treatment room. There were four residents self-administering medication who had been assessed as competent to do so. Medicines were kept in locked drawers in the resident's room.</p> <p>The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted. The CNM reported that controlled drugs are stored securely following requirements and checked by two staff for accuracy when being administered. Outcomes of as-required (PRN) medication were consistently documented.</p> <p>Administration records are maintained, and drug incident forms are completed in the event of any drug errors or resident refusals.</p>
Standard 1.3.13: Nutrition,	FA	The kitchen service complies with current food safety legislation and guidelines. The service employs two

<p>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>cooks in the kitchen and caters to 58 residents. One of the cooks works from Monday to Thursday while the other cook works from Friday, Saturday, and Sunday respectively.</p> <p>This food service audit was conducted by reviewing the documentation and records generated through the implementation of the service's food control plan. It included observations, discussions with the cook as to their routine handling practices relating to food safety. There is an approved food control plan for the service which expires on 13 April 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by a registered dietitian on 20 January 2022. The kitchen staff had 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 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 were maintained.</p> <p>The residents and whānau interviewed indicated satisfaction with the food service.</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 CNM reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/whānau is referred to the referral agency to ensure 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</p>	FA	<p>Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI assessments were completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the resident and their whānau and other health team members as appropriate. Additional assessments were completed according to the need (eg, behavioural,</p>

timely manner.		nutritional, continence, and skin and pressure risk assessments). The nursing team utilises standardised risk assessment tools on admission. In interviews conducted, whānau and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The assessment findings and input from residents and/or whānau inform the care plan and assist 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 were used for short-term needs. Residents in the dementia unit had twenty-four-hour activities care plans in place. Behaviour management plans were implemented as required. The CNM reported all residents in the dementia unit had management strategies for specific behaviours to guide staff. Whānau and residents confirmed they were involved in the care planning process.</p> <p>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, physiotherapists, district nurses, dietitians, and the GP.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. The CNM reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred. This was further confirmed by the GP during the interview. Care staff confirmed that care was provided as outlined in the care plan.</p> <p>A range of equipment and resources were available, suited to the levels of care provided based on the residents' needs.</p>
Standard 1.3.7: Planned Activities 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.	FA	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the activities coordinator. 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's social profile is completed for each resident within two weeks of admission in consultation with the family. The activities staff formulate the activity programme. The activities are varied and appropriate for people living with dementia, rest home, and hospital level of care. Residents' activities care plans were evaluated in a timely manner. Residents' meetings are conducted monthly by the activities coordinator and the management team.</p> <p>Twenty-four-hour activities care plans reflected residents' preferred activities of choice and were evaluated</p>

		<p>every six months or as necessary. Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections were suitable for the residents. There are regular outings/drives, for all residents and these are conducted in line with MOH Covid-19 guidelines.</p> <p>Whānau members reported overall satisfaction with the level and variety of activities 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>Residents' care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner.</p> <p>Care plan evaluations and review of interRAI assessments occur every six months or sooner if residents' needs change. The evaluations are carried out by the RNs in conjunction with whānau, residents, GP, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan.</p> <p>Short-term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and whānau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and 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 GP and the nursing team refer to specialist service providers and the DHB. Referrals are followed up regularly by the GP and nursing team. The resident and the family are 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. All cleaning, laundry, maintenance and kitchen staff have completed training in the safe handling of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate protective clothing and equipment, and staff were</p>

or hazardous substances, generated during service delivery.		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>	FA	<p>A current building warrant of fitness (expiry 01 June 2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the facility manager and observation of the environment. Hot water is tested to ensure it is within the required temperature range. The facility vehicle has a current registration and warrant and is maintained.</p> <p>The environment was hazard free, residents were safe, and independence was promoted in all areas including the dementia unit.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. There is a secure garden area accessible to residents living in the secure dementia unit. This area has two fences. The inside of the inner fence has recently been painted with garden images and bright flowers by children from the nearby school to make it more visually appealing. There is shade available for residents when outside.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were very happy with the environment. All residents and family members interviewed spoke positively about the changes the facility manager has made. Changes included painting inside, replacing the dining room furniture, purchasing new reclining chairs / lounge furniture with all except five chairs replaced as at audit, purchase of 12 low-low beds, air mattresses, sit up alarms, replacing duvet covers so residents have unique coverings for colour and interest, installation of a fish tank in two lounge areas, purchasing a bariatric wheelchair, and installing artwork on walls. The infrequently used children's playground has been removed from the courtyard and this area turned into a more usable area for residents, and landscaping done. Several bathrooms have been fully renovated in the East wing, and refurbishment of bathrooms was in progress in the secure dementia unit. Renovation has occurred in the kitchen with a new gas cooker and oven installed, and new commercial drier installed in the laundry following a fire in 2021.</p> <p>A 'Gas Safety and Compliance Certificate' for gas related work was sighted, and the 'Electrical Safety Certificate' following the installation of applicable appliances.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 16 rooms in the rest home/hospital that have a shared toilet between the bedrooms, one bedroom

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>has its own toilet, four bedrooms share a full ensuite between two rooms and 14 rooms have their own full ensuite. There are separate showers, toilets and bathrooms with toilets/showers combined. Sampled bathrooms have privacy locks.</p> <p>In the secure dementia unit, 10 bedrooms have an ensuite with a handheld shower. Staff advise these are rarely used and rather the main shower rooms are used. There are four bedrooms with an ensuite toilet and one room with no ensuite facilities. There are two other shower/toilets. These have a green door.</p> <p>There are other toilets for staff and visitors. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There is one bedroom being shared by two residents (spouses) otherwise all bedrooms are currently single occupancy. Where rooms are shared, approval has been sought. There are five other rooms that could have two occupants. These rooms are currently only used for one resident. There are no shared bedrooms in the dementia unit and each room was individualised to assist residents in identifying their own bedroom. 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>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<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. There are resting benches in corridors throughout the care home. These are referred to as 'bus stops'.</p> <p>The dining area in the dementia unit is clearly identifiable and the observed mealtimes were unhurried, calm and conducive to stress free dining. The lounge/dining room opens to a covered deck area in the secure dementia unit and links onto a ramp / walking path.</p> <p>Residents can access areas for privacy, in all areas of the home including the dementia unit if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	<p>Laundry is undertaken on site seven days a week by a cleaner who is assisted by care staff. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are usually returned in a</p>



<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>timely manner, with some exceptions noted.</p> <p>Each member of the cleaning team has attended suitable training, as confirmed in interview of cleaning staff and training records. Two cleaners are on site seven days a week, each have designated areas they are responsible for. One is also responsible for laundry. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The whanau/family members interviewed expressed satisfaction with cleaning and laundry services provided, with minor issues occasionally reported and addressed. The care home was observed as clean. Staff were vigilant with ensuring cleaning chemicals or equipment were not left unattended. Cleaning and laundry processes are monitored through the internal audit programme. Whanau/family members stated that when visiting, the care home always smells fresh and clean, and credit the facility manager with making changes to ensure this.</p> <p>A new dryer has been recently installed following the previous dryer catching on fire in 2021.</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 are 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. The current fire evacuation plan was approved by Fire and Emergency New Zealand on the 29 April 2021. A trial evacuation takes place six-monthly, the most recent being on 6 November 2021. The orientation programme includes fire and security training. Staff in all areas including the dementia unit, 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, consumables, and gas barbeque (BBQ) were sighted and meet the requirements for the maximum number of residents (63) and the water storage requirements for the region. A 1,000 litre water storage tank is located on site, with additional bottled water available. Emergency lighting is regularly tested. The facility manager has recently purchased a generator. This is tested regularly.</p> <p>Call bells alert staff to residents requiring assistance. Function is checked monthly as part of the internal audit schedule. Residents and families reported staff respond promptly to call bells and have no security concerns.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. Security cameras have been recently installed and monitor outside the facility and inside in communal areas. Signage alerts these are in use.</p> <p>A register is maintained by the administrator of all residents, their rooms, their level of dependency in the event of an emergency and any mobility devices used are listed.</p> <p>As part of the Covid-19 pandemic preparation, a one page summary of every resident has been</p>

		developed. This details the resident's name, room number, date of birth, allergies, advance directives, next of kin details, covid vaccination status, and has a current photo and list of current medical diagnosis and care needs. These are kept centrally and updated as required.
<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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by ceiling panels. Areas were warm and well ventilated, including with the use of ceiling fans in communal areas, throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection prevention and control programme that is reviewed annually. The review of the programme is completed by the clinical manager (CM) who is appointed as the infection prevention and control coordinator (ICC), supported by the CNM. A position description for the ICC was in place.</p> <p>The service has guidelines in place to manage and prevent exposure to infections. Infection prevention and control training is provided to staff, residents, and visitors. There were adequate supplies of personal protective equipment (PPE) and hand sanitisers in stock. Hand washing audits were completed as per schedule. Policies and procedures are documented and reviewed regularly. Staff are advised not to attend work if they are unwell or self-isolate and get tested if they have been in contact with a person who has tested positive for COVID-19. Most residents and all staff were vaccinated for COVID-19 and influenza. Completed records were sighted in all files sampled.</p> <p>There was 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 rapid antigen tests (RATs) are being conducted for staff and visitors when indicated prior to coming on site.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	The CM is responsible for implementing the infection control programme. The ICC indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infections rates information is shared in a timely manner. The ICC completed infection

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		<p>control training to keep their knowledge current.</p> <p>The ICC has access to residents' infection control data collected within the organisation and reported that there are sufficient resources and systems to collect all the necessary information. Surveillance, internal audits, investigations, and corrective actions are completed as required.</p> <p>Specialist support can be accessed through the district health board, the medical laboratory, external consultants, and the attending GP.</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>There are documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all the nurses' stations. Staff were 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>	FA	<p>Staff training on infection prevention and control is provided on an ongoing basis (eg, during orientation, shifts handovers, staff meetings, and in the annual in-service education programme). The in-service education is conducted by either the ICC, CNM, local laboratory, or other external consultants. Monthly infection audits were completed and evidence of this was sighted.</p> <p>The infection control training includes handwashing procedures, donning and doffing protective equipment, and regular COVID-19 updates. Records of staff education were maintained.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. The ICC collects infection surveillance data, analyses trends, monitors, reviews, and where possible implements corrective action plans to prevent recurrences. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings and management meetings. Evidence of completed infection</p>

and methods that have been specified in the infection control programme.		<p>control audits, monthly reports, and annual reports were sighted.</p> <p>All staff interviewed confirmed that they are informed of infection rates as they occur. The GP was informed on time when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.</p>
<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. A registered nurse is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The RN/restraint coordinator demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities involved.</p> <p>On the day of the audit, twelve residents, all hospital level of care, were using a restraint at their or whanau/family/EPOA's request for safety and comfort. Bedside rails, a three point harness or a lap belt were the forms of restraint in use. The resident and family are consulted about the process, associated risks and sign both the restraint consent form and review and sign the information recorded in the resident's care plan as part of this process.</p> <p>One other resident was using an enabler (bedrail). Enablers are the least restrictive and are only used voluntarily at a resident's request. This was verified by interview with the applicable resident and staff, and review of associated documentation.</p> <p>All staff are provided with training on restraint and enabler use as part of orientation programme and annual training is given as part of the annual staff training/competency programme.</p> <p>There were 12 residents with restraints in use when the facility manager purchased the care home in May 2021. The facility manager has purchased 12 low-low beds, and several mattresses for the floor and sit up alarms as part of a strategy to reduce the use of restraint. The facility manager, CHM and restraint coordinator advise they are working towards having zero restraint in line with the new standards.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration</p>	FA	<p>The registered nurse/restraint coordinator has been in the role four months, since employment, and confirmed being provided with training on the restraint minimisation and safe practice policy and processes. The RN/restraint coordinator has a signed position description that details the roles and responsibilities, and there are clear lines of accountability for restraint use. The approval process includes the RN/restraint coordinator, the facility manager, a GP and family/whanau/EPOA. The policy and RN / restraint coordinator advise specialist cultural advice will be sought where required. The required approvals were sighted in records of restraint. Restraint use is discussed at staff and RN meetings.</p>

of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with the input from the resident's family/whanau/EPOA. The individual resident's general practitioner is involved in the final decision on the safety of the use of the restraint.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and any associated risks. The restraint use was to help ensure the resident's safety and security. Completed assessments were sighted in the three applicable residents' records reviewed. A family member was interviewed and confirmed they wanted bedrails in use when their family member is in bed and are regularly involved in discussions on these.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is being actively reviewed with the recent arrival of additional equipment (eg, low-low beds, sit up alarms, and mattresses for the floor), that may be used to provide safe alternatives to restraint. The restraint coordinator discussed the alternatives to restraint that have been considered, and this is part of the assessment process prior to the use of restraints.</p> <p>The use of restraint was included in the applicable resident's interRAI assessments sampled and in their long term care plan, which also details the ongoing monitoring required. Records of monitoring sighted demonstrated regular monitoring of the resident was occurring with infrequent exception. This is not raised as an area for improvement as the system supports timely monitoring and this was predominantly occurring.</p> <p>A restraint register is being maintained and is updated as required and is discussed by the CNM and at registered nurses' monthly meetings.</p> <p>Staff have been provided with training on the use of restraints and enablers as a component of the orientation programme, and the annual ongoing education programme. Thirty one staff completed restraint minimisation training in December 2021. Thirty staff completed training on managing challenging behaviours in October 2021.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes</p>	FA	<p>Regular reviews are conducted on residents with restraints in use and this was evident in the records sampled. Reviews occur at least six monthly, and included discussions on alternative options,</p>

of restraint.		<p>effectiveness, and changes required to supports and the care plans, the timing of restraint use and could this be minimised, and any concerns.</p> <p>A family member interviewed confirmed being involved in regular discussions about the use of restraint, and whether this was still needed. Any associated risks are identified and included in the care plan, which is signed by the whanau/family member/EPOA.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator undertakes a three monthly review of residents with restraint use, in addition to the six monthly interRAI reassessment and care plan review. A regular restraint audit (last completed in August 2021) is also undertaken. These processes included evaluating the restraint used and type, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, and the competency of staff, compliance with policy, the appropriateness of restraint/enabler education and any feedback from the doctor, staff and families.</p> <p>Any changes to policies, guidelines, staff education/training and processes are implemented if indicated.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>The service engaged in a quality initiative project to improve the management of impaired skin integrity (rashes, redness) in groin areas in 18 affected residents.</p> <p>Monthly quality indicators showed an increase in the number of skin irritation, rashes/redness in groin areas over two months (June and July 2021) in 18 residents assessed as requiring hospital level of care. This prompted the service to investigate to find out the root cause of the problem and ways to improve clinical care. It was discovered that, had the service implemented prompt interventions to manage the skin problems, the numbers could have been reduced. All this was attributed to a lack of adequate skills and techniques in managing residents with skin problems.</p> <p>The following aims/goals were developed to address the</p>	<p>The achievement of the quality improvement projects in good practice and implementation of the programme is rated beyond the expected full attainment. The project included a documented review process that includes the analysis and reporting of findings. There was a significant reduction in the number of skin irritations from 18 to two residents. On further review, by extending the course of treatment and prescribing new medication on the other two residents the numbers dropped to zero. Prompt reporting by care staff to registered nurses when there is any sign of a breakdown in skin integrity identified in any resident now occurs.</p> <p>Positive feedback was verified from the residents and family through interviews conducted. The service achieved zero problems of skin irritations in all residents up to the audit date.</p>



		<p>problem:</p> <ul style="list-style-type: none"> <li>- To reduce the occurrence or re-occurrence of skin irritation (redness/rashes) in groin areas to the best possible levels by having preventive measures in place.</li> <li>- Early detection and management of skin irritation to prevent escalation.</li> <li>- To improve residents' quality of life by reducing the severity of skin irritation.</li> <li>- To ensure a reduction in the time spent attending to residents with skin irritations by showering residents twice a day and ensuring proper hygienic measures are followed.</li> <li>- Reduce costs of overusing incontinent products.</li> <li>- To review the impact of the problem on the residents, family, and nursing care provided.</li> </ul> <p>The management team held a meeting with the registered nurses, care staff, and the general practitioner to come up with ways to reduce the problem identified and improve the nursing care in the process. Staff were trained in skin care, use of incontinence products, toileting regimes, and internal audits were completed to assess any gaps in the process.</p> <p>The GP reassessed all the affected residents and commenced them on a combination of a short course of anti-fungal ointments. Short-term care plans were developed with detailed interventions to guide staff for all residents identified with skin problems and these were reviewed weekly. Staff training on skin integrity, including pictures of layers of the skin were displayed in the nurse's station, regular handovers at beginning of each shift were conducted emphasising on quality nursing care on affected residents. All these interventions resulted in a decrease in skin irritations from 18 to zero cases.</p>	
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End of the report.