

Munro Resthomes Limited - Malyon House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Munro Resthomes Limited
Premises audited:	Malyon House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 1 February 2022 End date: 2 February 2022
Proposed changes to current services (if any):	The service is also certified for Hospital – medical level care. This should be included in the services audited above
Total beds occupied across all premises included in the audit on the first day of the audit:	55

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

Malyon House provides rest home and hospital (geriatric and medical) level care for up to 57 residents with an occupancy of 55 residents on the days of audit. The service is managed by a director (registered nurse), facility manager (registered nurse), clinical manager (registered nurse) and administration manager.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, and staff. The residents and relatives interviewed were very complimentary about the care and support provided.

This audit identified three shortfalls to care planning, and medication documentation.

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.	Green	Standards applicable to this service fully attained.
--	-------	--

Malyon House strive to ensure that care is provided in a way that focuses on the individual, values residents' independence and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' individual cultural and spiritual needs are met including recognition of Māori culture. Care plans accommodate the choices of residents and/or their family. Policies are implemented to support residents' rights, communication, and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

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.
---	--	--

The management team are responsible for the day-to-day operations of the facility. Malyon House is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Meetings are held to discuss quality and risk management processes. Corrective actions are developed and implemented as required. Health and safety policies, systems and processes are implemented to manage risk.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whanau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals. Documented medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent care assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities team implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All food and baking are prepared and cooked on site. The menu has been reviewed by a dietitian and a current food control plan is in place. Residents interviewed were complimentary of the food service. .

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraints and two residents with an enabler.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	--	---

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has attended external education and coordinates education and training for staff. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. Infection prevention and control is integrated into full staff and registered nurse meetings. There is a suite of infection control policies and guidelines to support practice. The Covid-19 preparedness framework reflects in all levels of the infection control programme. A monthly infection control report is completed for analysis and benchmarked with other facilities within the Cavell group. There had been one norovirus outbreak in January 2021.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	1	1	0	0
Criteria	0	91	0	1	1	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>A policy relating to the Code of Health and Disability Services Consumer Rights (the Code) is implemented. Leaflets on the Code are accessible to residents and their families. Staff receive training about the Code during their induction to the service, with this provided annually through the staff education and training programme. A staff education session on the Code was held in 2021 around rights and advocacy services.</p> <p>Four managers (the director, and facility, clinical and administration managers) and 10 staff (three care assistants, two registered nurses, the cook, laundry assistant, cleaner, diversional therapist, maintenance) all stated that they understood the Code.</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</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. Systems are in place to ensure residents and where appropriate, their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and RNs interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. General consents were obtained on admission and sighted in eight resident files reviewed (including one resident on</p>

informed consent.		younger persons with disabilities contract and one resident on respite). Advance directives were sighted in each resident's file relating to resuscitation status, having been completed by the resident (where they were competent to do so) in the presence of the general practitioner. Policy dictates that where a resident is not competent to make an advance direction around resuscitation, resuscitation will be provided.
<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	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of how to access advocacy services.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility. The service has continued to work with the community as much as possible to maintain links. During periods of lockdown, there have been restrictions on entertainers coming into the service however whenever possible, these have been renewed once restrictions have been lifted. Residents are encouraged to have visitors and to go out to the community as much as possible noting that Covid 19 and the pandemic restrictions have placed a hold on this during 2021 and year to date. There is a café located next door to the facility and residents and family stated that they enjoyed visiting.</p> <p>Family interviewed confirmed that they were well informed around Covid-19 and had received updates and information from the service around policies, systems, and expectations in a timely manner.</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 service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with residents and family members confirmed that they understand the complaints process. They also confirmed that management and staff are approachable and readily available if they have a concern.</p> <p>There have been five complaints lodged with the service in 2021 and one in 2022 year to date. Three</p>

		complaints reviewed had been managed appropriately with acknowledgement, investigations and resolved to the satisfaction of the complainant. A review of the complaints register evidenced that the appropriate actions have been taken to improve the service. There have not been any external complaints to the service since the last audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The clinical manager (CM) discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings.</p> <p>Eight residents (six at hospital level of care including two palliative care and one respite, and two at rest home level including one respite) and seven relatives interviewed (six with a family member using hospital level of care including one under a Long-Term Support– Chronic Health Condition [LTS-CHC] contract and one rest home) reported that the residents’ rights were being upheld by the service.</p>
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy, and dignity. The residents’ personal belongings are used to decorate their rooms. Care staff stated that they knock before going into a resident’s room and this was observed on the day of audit. All toilets and bathrooms have locks to ensure privacy. The residents interviewed stated that their privacy was observed.</p> <p>House rules are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources</p> <p>Abuse and neglect training is part of the annual compulsory training schedule with this last provided in 2021. Staff and the GP interviewed confirmed that there was no evidence of abuse or neglect. The managers confirmed that there had not been any incidents around abuse or neglect since the last audit. Spiritual needs are individually identified as part of the assessment and care planning process.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their	FA	The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there was one resident that identified as Māori. Interview with the Māori resident confirmed that their cultural needs were met. Discussions with staff confirmed that they are aware of the need to respond with appropriate cultural safety. The service has established links with a Māori kaumātua (NASC assessor) who assists in reviewing policies and protocol and is available to provide advice at any time and assists in review of relevant policies and plans. There is a now-retired

individual and cultural, values and beliefs.		care assistant who identifies as Māori who no longer works at the service but has said that they are happy to assist in a similar manner on a voluntary basis.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan in consultation with the resident (as appropriate) and/or their family/whanau. Care staff interviewed could describe how they would communicate with non-English speaking residents with the use of body language and pictorial cards. Cultural awareness training is part of the annual compulsory training schedule.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents and relatives interviewed reported that the staff show respect towards them. Job descriptions include responsibilities of the position. The employee agreement and orientation provided to staff on induction includes standards of professional conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents with needs relating to rest home and hospital level care. The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to complete orientation and complete the online training programme. There is a clinical leadership team of experienced RNs (director, facility, and clinical managers along with RNs) to guide and mentor the caregivers. The director, facility manager and clinical manager are all regularly working RN shifts on the floor to ensure that there are no gaps while there is a shortage of registered nurses. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Residents and relatives interviewed confirmed on interview that the staff and management are approachable and

<p>conducive to effective communication.</p>		<p>available. Twelve incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the six-monthly resident/family meetings. Interpreter services are available as required. The management team provided communication around Covid 19 and any changes in practice in a timely manner to residents and family members via email, phone, and face to face. Residents and family confirmed that they were very satisfied with the amount of information provided.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Malyon House is owned and operated by Munro Resthomes Limited. The service provides rest home, hospital (geriatric and medical) care for up to 57 residents. Eight beds in one wing are rest home level care only and the remaining forty-nine are dual purpose beds. On the day of audit, there were 55 residents (15 residents receiving rest home level care, including one respite resident, and 40 receiving hospital level care including one younger person with disability (YPD) contract, three under a palliative care contract, one resident on a long-term support – chronic health contract (LTS-CHC) and one respite. All other residents were under the Age-Related Residential Care (ARRC) contract.</p> <p>The service is part of the Cavell Group. There are two directors including one who is hands-on in managing the service. Malyon House has a strategic plan (developed by the Cavell Group) and 2021-2022 business plan that cascades from the strategic plan. There is a philosophy of care and mission statement which links to the organisation’s strategic plan and is reviewed annually with the two directors. The facility manager reports to the director regularly on a variety of operational issues.</p> <p>The facility manager is a registered nurse with a current annual practicing certificate (APC) who has been in the role for one and a half years. They have three years in a clinical manager role in the community prior to coming to the service and has 12 years’ experience in aged care nursing. The facility manager is supported by a clinical manager who was initially a registered nurse at the service and now has five years’ experience in the role as clinical manager.</p> <p>During discussions with the management team, they reported a high staff turnover, in particular registered nurses. The service has struggled to replace nurses when they have left. Managers have taken on shifts to ensure that there are always sufficient nursing staff on duty on each shift.</p> <p>The director, clinical and facility managers have all completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months and in clinical management.</p>
<p>Standard 1.2.2: Service Management</p>	<p>FA</p>	<p>The director, facility and clinical managers are all RNs who are able to provide clinical oversight at any given time if one is on leave. The director, administration manager and the facility manager can provide</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>		<p>support if any of them is on leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Quality and risk management systems are in place. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.</p> <p>The quality and risk management programmes include an internal audit programme and data collection, analysis and review of adverse events including accidents, incidents, infections, wounds, and pressure injuries. Corrective action plans are put in place when issues are identified and there is evidence of resolution of issues in a timely manner.</p> <p>There is evidence of results being communicated regularly to staff through six weekly staff meetings, monthly management meetings, monthly health, and safety meetings and six weekly clinical meetings. There are also six-monthly resident and family meetings. Meeting minutes reviewed showed that all aspects of the quality and risk management programme are reviewed and discussed at relevant meetings. The minutes are also put onto the staff noticeboard.</p> <p>Family meetings were not able to be held in 2021 and a Survey Monkey survey was completed for family only and 58% of respondents stated that they were very satisfied and 29% stated that they were satisfied with the service. The annual resident and family satisfaction survey was last completed in September 2021. Collation of the data was completed with documentation of a 94% satisfied or very satisfied (noted that 77% were very satisfied). This is similar to the 2020 satisfaction survey which indicated that 100% of respondents were satisfied or very satisfied. A food satisfaction survey for residents was completed in 2021 with only two of the 16 respondents indicating that they were not satisfied and 88% of the respondents stated that they were satisfied or very satisfied. There were no trends in any of the feedback although the service did respond to any specific complaints if the respondent had put their name on the return.</p> <p>The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored. One of the directors is the health and safety officer and has completed the specific health and safety training required. A care assistant is also identified as a health and safety representative. They have been in the service for five and a half years and have been in the role for</p>

		<p>over three years. They were able to explain the role when interviewed. There is a health and safety monthly meeting with a focus on promoting safe work habits amongst employees. Health and safety is also discussed at the staff and management meetings. Falls prevention strategies are in place including the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective actions. The service collects a set of data relating to adverse, unplanned, and untoward events. This includes the collection of incident and accident information. The data is trended and linked to the quality management systems. A monthly incident report is completed which includes an analysis of data collected. Staff meeting minutes review the analysis of incident and accident data and corrective actions. Twelve accident/incident forms sampled included RN assessment following an incident. Incidents reviewed included five where a resident had had an unwitnessed fall or had hit their head. All five showed that neurological observations had been completed, however the frequency of completion did not occur within the stated frequency in the policy (link 1.3.6.1).</p> <p>Discussions with the director and managers confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been seven section 31 incidents reported in late 2021 to 2022 around registered nurse shortages noting that in each case, the shifts had been covered by a manager. There was a coroner's investigation in 2021, two reports for pressure injuries in November 2020, and a change of facility manager in June 2020. A norovirus outbreak was notified to Public Health in January 2021.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities, and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including general practitioner (GP), pharmacist and physiotherapist. Nine staff files were reviewed (one clinical manager, one facility manager, three RNs, two caregivers, one cook, one diversional therapist). Evidence of signed employment contracts, job descriptions, orientation and training were sighted. Annual performance appraisals for staff are conducted for all employees and were sighted on staff records reviewed.</p> <p>Newly appointed staff complete an orientation that is specific to their job duties. Interviews with caregivers described the orientation programme that includes a period of supervision. The service has a training policy and a scheduled in-service education planner. The in-service schedule is implemented, and attendance is recorded. There are implemented competencies for RNs including medication,</p>

		<p>restraint, and the use of a syringe driver.</p> <p>There are 11 RNs (including three casual) with seven identified as being interRAI trained (including the director, facility, and clinical managers). Registered nurses have access to training through the DHB noting that some of this was stopped in 2021 as a result of the Covid 19 response. All nurses have continued to have sufficient training relevant to their role that meets the needs of their annual practicing certificate. The main focus for the management team has been to ensure that there are sufficient numbers of nurses on each shift.</p> <p>Caregivers who have gained the New Zealand Qualification Authority (NZQA) certificate or are in training are as follows: seven have completed level 2, seven have completed level 3, and 16 have completed level 4. Three caregivers are currently enrolled in level three and five in level four training.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and clinical manager both work full-time from Monday to Friday and share the 24/7 on call duties. The director is also on site two days a week. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and relatives confirmed that there are sufficient staff on duty.</p> <p>The facility is split into the ground floor (Ruby, Sapphire, Jade and Topaz wings) and upstairs (Opal and Amber wings).</p> <p>On the ground floor there is a total of 35 residents (26 hospital and 9 rest home residents). Upstairs there are 20 residents in total (6 rest home and 14 hospital).</p> <p>There are 11 caregivers on duty in the morning (five on a long shift and six short shifts (including four who work from 6.45 am-1 pm). Three caregivers are rostered upstairs with one identified as supporting residents to shower and there are seven downstairs. In the afternoon there are eight caregivers including two long, five short 2.45 pm-9.15 pm and one 4 pm-8 pm. Of the eight, three caregivers are rostered to the upstairs wings and the rest are downstairs. Allocation of caregivers can be adjusted at any time according to acuity and numbers. There are two caregivers on night shift (one upstairs and one downstairs). There are two registered nurses on the morning and afternoon shifts and one registered nurse on the night shift. There is an extra registered nurse on the morning shift four days a week (9 am-1 pm) predominantly to help with wound care.</p> <p>There is a centrally located lift and stairs that allows staff to move between the up and down stairs areas easily to answer call bells etc.</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>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff could describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident information is kept in integrated files. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner. Residents' files are protected from unauthorised access (hard copies kept in a locked cupboard) with electronic files being password protected. Archived records are secure in locked areas.</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 service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Information gathered at admission is retained in resident's records. Relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement and financial information with the administration manager. The service has a well-developed information pack available for residents/families/whanau at entry including admission information related to respite and palliative care. An advocate is available and offered to family. The admission agreement aligned with the age-related residential care agreement (ARRC). Eight admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</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 are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. Overall, planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. The family are informed of any transfers.</p> <p>Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-medicating on the day of audit. All had competencies in place, which had been reviewed by the GP three monthly and medications were kept</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>securely within the resident's room.</p> <p>Standing orders are in use and comply with legislative requirements and the Ministry of health standing order requirements</p> <p>The facility uses an electronic medication management and sixteen medication charts. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs have responsibility to administer medications. Staff had current medication competencies and received medication related education and training in the last year. Registered nurses have syringe driver training and competencies. The temperatures for the medication fridges and medication rooms are checked daily and were within safe limits. Eye drops and topical medications were dated once opened</p> <p>Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted and effectiveness post administration documented, however, staff were transcribing instructions around medication into the care plans.</p> <p>Education around safe medication administration has been provided. Medications were stored safely in both units. The medication round was observed during lunchtime and correct procedures were followed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All baking and meals are cooked on-site at Malyon House. The kitchen is spacious and includes areas for food preparation, cooking, baking, serving, and cleaning areas. There is a team of kitchen staff including two cooks and four kitchen assistants. Both cooks and all kitchen assistants have completed food handling through orientation and via external national programmes. An external consultant dietitian reviews the summer and winter menus, which were last reviewed by the dietitian in 2020. There is access to a community dietitian.</p> <p>There are two choices for the lunch meal and two choices at night. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. There are lists maintained within the kitchen of the resident's key alerts regarding allergies or food dislikes/preference for staff reference. Special equipment such as 'lipped plates' and built-up spoons are available as required. Food is transported to five smaller dining room areas in bain-maries and is plated in the kitchenette by the cook and delivered and served to residents by the care assistants.</p> <p>Cooked/served food temperatures are completed prior to transport and completed before serving as part of the internal audit programme (records sighted). Kitchen fridge/freezer temperatures and food temperatures are monitored electronically. Corrective actions for temperatures outside of range are documented and re-tested. Food stored in the fridge and chillers is covered and dated. There are designated shelves within the chiller for dairy, meat, and vegetable/grocery items. Dry goods are stored</p>

		<p>in dated sealed containers in the pantry and kept off the ground. Chemicals are stored safely. Cleaning schedules were sighted and maintained. The service has a current approved food plan that expires 30 September 2022.</p> <p>All residents have a nutritional profile completed on admission, a copy of which is provided to the cook who is also notified (daily where necessary) of any dietary changes, weight loss or other dietary requirements. Residents/relatives interviewed spoke positively about the food provided.</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 service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whanau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care. The facility has a waiting list of potential residents. There is evidence of regular communication with family/whanau regarding timeframes for placements.</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>Admission documentation includes information obtained on interview with resident/relative or advocate, from medical discharge summaries and information received from needs assessors. The RNs complete an initial assessment on admission, including risk assessment tools such as coombes (falls risk) assessment, waterlow (pressure risk) and nutrition assessments as appropriate. The facility has embedded the interRAI assessment protocols within its current documentation. The initial assessment, short and long-term care plan templates were completed in all long-term resident files reviewed. The respite resident and resident on palliative care had a suite of initial assessments completed.</p> <p>InterRAI assessments including assessment summary, MDS comments and client summary reports were evident in printed format in all files. An interRAI reassessment has been completed where health changes for residents have occurred. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. In all eight resident files reviewed (three rest home and five hospital), assessments were conducted within the required timeframes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity</p>	FA	<p>Three rest home and five hospital files reviewed included an initial assessment and (initial) care plan. Long-term care plans were in place for the long-term residents. Short-term care plans were available for use to document any changes in health needs. Short-term care plans were evidenced for wounds, skin tears, short course antibiotics and weight loss. Residents' long-term care plans reviewed were resident-focused and individualised to promote independence with a flexible goal. Relatives and residents</p>

<p>of service delivery.</p>		<p>interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed six-monthly.</p> <p>Short-term care plans were evaluated at regular intervals and either resolved or added to the long-term care plan if an ongoing problem. Medical GP notes and allied health professional progress notes were evident in the six long term residents integrated files sampled. Relatives interviewed were complimentary about the staff, service delivery and confirmed they are kept informed of any significant events and changes in health status. Family contact forms sighted in the resident's individual record evidenced family are informed of any health changes, incidents/accidents, infections, specialist visits, care plan review and weight loss. Family is invited to attend care review meetings.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition changes, the RN will initiate a GP/NP consultation. Staff stated that they notify family members about any changes in their relative's health status, however, not all care plans included interventions to support all changes in residents' needs.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted. Specialist continence advice is available on request.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progression. There were thirteen wounds managed at the time of the audit. Wounds included include one stage two facility acquired pressure injury, one chronic venous ulcer and skin tears. The RNs interviewed described the referral process should they require assistance from a wound specialist.</p> <p>Monitoring forms are in use as applicable, such as weight, repositioning, vital signs, neurological observation, pain, and wounds. Pain and neurological observation monitoring requirements did not occur consistently when required. .</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities team (one diversional therapist and two activities assistants) coordinate and implement the activities programme across the rest home and hospital. The programme is seven days a week including public holidays. Activities staff attend on site and organisational in-services relevant to their roles. Volunteers visit throughout the week and on weekends. Volunteers include a van driver and one calling Bingo. Volunteers adhere to the Covid-19 mandate. The driver has a current driver's licence, first aid certificate and hoist competency.</p> <p>The diversional therapist makes contact with a resident and their family/whānau within a week of admission. A map of life and an activity care plan is completed within three weeks of admission in</p>

		<p>consultation with the resident/family/whānau. The map of life is displayed in residents' room (with consent) which has provided opportunities for all staff and visitors to get to know the resident and their past interests sooner. The activities plan is reviewed six-monthly with the long-term care plan.</p> <p>The DT interviewed explained communication and information sharing with families occurs through a dedicated closed group Facebook page.</p> <p>Attendance sheets and individual progress notes are maintained. Feedback on the programme is received through three monthly resident meetings and annual surveys. Residents and relatives interviewed reported that they or their loved one enjoyed the activities offered.</p> <p>The activities programme has set activities with the flexibility to add activities that are meaningful and relevant for the resident group including: exercises such as yoga to support the falls prevention programme; themed events and celebrations; baking; sensory activities including colour painting; regular outings and drives. Community links are maintained through regular entertainers (within the Covid-19 mandate) and church services.</p> <p>The DT could explain the support provided to the YPD resident (resident was unable to be interviewed) to maintain their regular appointments and outings to the gym and swimming pool.</p> <p>One-on-one activities include balloon tennis, manicures, and news reading. On the day of the audit residents were observed to meet outside for morning tea and news reading with the activities assistant. There are several homelike lounges and dining areas where activities occur and where resources are available for residents and staff. Daily contact is made with residents who choose not to be involved in the activity programme.</p> <p>The DT introduced with the local DHB 'eat well for bingo' to integrate the food guide in an interactive bingo game that making learning about healthy eating for healthy ageing fun. The activities team is responsible for structuring food and drink opportunities as part of the activities programme; this will include Milk Day Mondays, High tea Tuesdays, Thirsty Thursdays, and Fun Fridays.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In files sampled, all initial care plans were evaluated by the RNs within three weeks of admission. The long-term care plans reviewed were evaluated at least six-monthly or earlier if there was a change in health status in six of eight files sampled (two of the resident's files reviewed had not been at the facility for six months). There is at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing. Where progress is different from the expected goal, the service responds by initiating changes to the care plan and goal.</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>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referral processes are documented and in place to guide staff to ensure residents are supported and referrals are appropriately facilitated to meet the needs of residents receiving services in this organisation.</p> <p>Residents interviewed reported they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. If a resident wishes to change facilities to another health and disability service, the NASC service is contacted, and the service provider assists as much as possible with arranging the transfer once approved by the NASC service coordinator concerned. Examples of referrals sighted were to: older person's mental health service; podiatry; physiotherapy; and skin specialist. There is evidence of GP discussion with families regarding referrals for treatment and options of care.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies in place for waste management, waste disposal for general waste and medical waste management. There are approved sharps containers in use for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals in use are stored securely on the cleaner's trolley. Laundry and sluice rooms are locked when not in use. Material safety data sheets are available in all key areas. The hazard register identifies hazardous substances. Gloves, aprons, and goggles are available in key areas for staff. Staff receive education on chemical safety. Interviews with care assistants described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires 3 August 2022. There is a part-time maintenance person on duty and is responsible for the comprehensive planned maintenance programme. Reactive and preventative maintenance occurs. Electrical equipment has been tagged tested and calibrated annually. There is sufficient medical equipment to meet resident needs. Interviews with care assistants confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>Malyon House provides rest home and hospital level care. The care facility is across the ground and first floor and divided into five communities each with a lounge and dining area. There are cleaning cupboards, a sluice and plenty of storerooms on each floor. More able residents including YPD are on the ground floor.</p>

		<p>There are several communal areas provided for both groups and individuals. The interior of the building is maintained with a home-like décor and furnishings. The corridors are wide with handrails in place. Residents were observed to safely mobilise throughout the facility. Hot water temperature checks are conducted and recorded monthly and maintained at 45 degrees Celsius. Electrical testing, tagging and calibration of medical equipment occurs annually.</p> <p>The facility has a lift between the floors which is spacious enough to accommodate ambulance transfer and kitchen equipment. The archive, chemical storage room, laundry and kitchen is situated in the basement with easy safe access for delivery trucks. The basement is for staff access only.</p> <p>There are several quiet seating nooks throughout the facility providing quiet low stimulus areas and privacy for residents and visitors. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn, and gardens.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All but one of the bedrooms are single occupancy (with one bedroom able to accommodate two beds) and have full ensembles with disability showers. There are communal toilets located closely to the communal areas on both floors. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. Regular audits of the environment are completed as per the quality programme. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment.</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>The residents' rooms are spacious and meet the assessed resident needs. There is one double room in the Ruby wing, which had single occupancy on the day of the audit. Residents can easily manoeuvre mobility aids around the bed and personal spaces. The bedrooms are personalised. All beds are of an appropriate height for the residents. Care assistants interviewed reported that rooms have sufficient space to allow cares to take place and staff were seen to use hoists. Residents interviewed were happy with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	FA	<p>There are combined lounge and dining rooms in each wing along with a kitchenette. There is also a large communal activities room on the ground floor. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit.</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>Residents interviewed reported they can move easily around the facility.</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>Malyon House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There are dedicated laundry and cleaning staff. Staff attend infection control education.</p> <p>The cleaning and laundry services are available seven days a week. There is a separate laundry area where the laundry staff launders all linen and personal clothing. Manufacturer's data safety sheets are available. There is appropriate protective clothing such as aprons, gloves, and masks available. The cleaning trolley is locked away in a cleaner's room when not in use.</p> <p>All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audits are conducted. Internal audits and resident satisfaction surveys identified no areas for improvement. The cleaner and laundry assistant interviewed confirmed the cleaning processes include requirements to protect against Covid-19.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management plans are reviewed and in place to guide staff in managing emergencies and disasters. There is an emergency/disaster management manual available for staff, residents, and visitors in the event of specific emergencies/disasters (including fire, earthquakes, floods, storms, tsunami, and gas leaks). Fire evacuation drills are scheduled and conducted six-monthly. The last fire evacuation drill occurred on 4 January 2022. External providers conduct system checks on alarms, sprinklers, and extinguishers. The service has a generator for emergency power. There is a civil defence kit available, first aid supplies and a dedicated storeroom for emergency supplies. Staff complete first aid certificates.</p> <p>There is alternative gas heating and cooking available (BBQ). Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There were sufficient emergency supplies of stored water available as per the region requirements. Call bells were evident in residents' rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is secured at night. There are security cameras in the hallways, basement, and the main entrance. All exit doors are secure and alarmed at night.</p> <p>There are automatic release buttons on all exit doors in case of an emergency.</p>

<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>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Heating and cooling is centrally managed with heat/cooling pumps throughout the facility. Staff are easily able to adjust the temperatures to suit resident's needs. Residents and family interviewed stated the environment is warm and comfortable.</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>	<p>FA</p>	<p>Malyon House has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control nurse and responsibilities for the role is described in the job description. The infection control team is made up of the clinical manager, the infection control coordinator (a registered nurse who is newly appointed to the role in January 2022) and the RNs. Infection control is linked into the incident reporting system. Infection control data is discussed at the monthly infection control meeting and linked to the clinical, staff and quality meetings. Monthly data is reported to the Cavell group for benchmarking with other facilities. There are six monthly infection control meetings with the Cavell Group.</p> <p>The infection control programme is well established at Malyon House and has been reviewed in the past 12 months.</p> <p>Resident education occurs during cares or opportunities at resident meetings.</p> <p>There is as policy and procedure in line with Covid 19 framework that defines what staff and visitors should do if they are unwell. Staff interviewed were able to describe this process.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>A registered nurse at Malyon House is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. External resources, support and access are available from the Ministry of Health, district health board, local GP and nurse practitioner from Cicada health when required.</p> <p>Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>Staff were observed to practice good handwashing techniques.</p> <p>There are sufficient stock including isolation kits, masks, and other PPE. Staff interviewed confirmed they adhere to cleaning practices for equipment use between residents, reusable items but also touch</p>

		screens and computer equipment.
<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 infection control policies and procedures appropriate that reflects good practice. Policies are available electronically on file and in hard copy. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies have been reviewed and updated. Policies include information and a response framework on Covid-19 preparedness including cleaning and laundry practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. The infection control coordinator has external infection control training scheduled. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p> <p>Infection control education has been provided for staff, on orientation and annually. Staff have completed competencies for handwashing and the correct use of personal protective equipment (PPE). Discussions around the facility's Covid-19 preparedness strategy is included in regular meetings, handovers, and on flow charts displayed on the noticeboard.</p> <p>Outbreak management and pandemic planning is included in the compulsory training schedule.</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</p>	FA	<p>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Short-term care plans are used. Surveillance of all infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated, and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner.</p>

programme.		<p>There is close liaison with the general practitioners that advise and provide feedback/information to the service.</p> <p>A facility Covid-19 preparedness framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in electronically, wear a mask, show a vaccine passport on entry, complete a health declaration and Covid QR scanning. There are special arrangements in place for children and unvaccinated visitors.</p> <p>The facility was issued with a stock of Covid-19 rapid antigen tests.</p> <p>There had been a norovirus outbreak in late January 2021, the outbreak was of short duration and appropriately managed with notification to Toi te Ora Public Health. Documents reviewed included a debrief meeting with staff and lessons learned.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had no residents using restraints and two residents with an enabler as requested by the resident (one with a bedrail and one with a lap belt). Staff training has been provided around restraint minimisation and management of challenging behaviours.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	There is a medication policy in place that describes the definition and risks associated with transcribing. The facility uses a paper-based long term care plan template with the resident demographics, medical conditions, and current medication on the first page. Three of six long term care plans reviewed evidenced the practice of transcribing the medication (including form, dosage, and frequency) onto the care plan.	Three of six long term care plans reviewed evidenced the practice of transcribing.	<p>Ensure transcribing of medication does not occur.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services</p>	PA Low	Eight files were reviewed. Care plans were in place for all residents that address their	(i) The resident on palliative care was observed in their room to be comfortable,	(i) Ensure interventions

<p>and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>medical conditions, however one care plan did not include all interventions. Monitoring for pain in two of eight and neurological observations in five of five forms were not completed within policy requirements. Care assistants, DT and RNs interviewed stated they are knowledgeable with the needs of the residents. .</p>	<p>on oxygen and on an air alternating mattress. There was a care plan in place to manage pain and syringe driver requirements, however no interventions recorded for the management of comfort and respiratory needs. The family member interviewed was complimentary of the care their relative receives</p> <p>(ii) Pain assessments are completed at admission and six-monthly, however two hospital residents with acute pain did not have regular pain monitoring completed.</p> <p>(iii) A sample of incident reports were reviewed. Post fall assessments were completed for all falls and next of kin were informed. Five of five unwitnessed falls had neurological observations completed however the frequency of completion did not occur within the stated frequency in the policy for all five reviewed.</p>	<p>are documented in detail to guide staff in the management of a resident needs/risks.</p> <p>(ii)-(iii) Ensure monitoring occurs as required in the policy.</p> <p>60 days</p>
--	--	---	---	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.