

# Agape Care Warkworth Limited - Leigh Road Cottage

---

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Agape Care Warkworth Limited

**Premises audited:** Leigh Road Cottage

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 21 February 2017 End date: 21 February 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 26

# Executive summary of the audit

---

## Introduction

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

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

## General overview of the audit

Leigh Road Cottage is currently owned and operated by a limited company. The providers own two separate full secure dementia facilities in different localities, North of Auckland. Leigh Road Cottage provides rest home and dementia level care to a maximum of 30 residents. On the day of the audit there are 26 residents. Two residents are rest home level who do not have dementia, but have chosen to stay at this facility. A review process and authorisation is in place for these two residents.

This provisional audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess the level of conformity of the current provider prior to the facility being purchased. A certification audit was completed 17 January 2017 against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with residents, relatives, staff and management. As part of this provisional audit, an interview was completed offsite with the prospective owner and added as an addition to the January certification report.

The prospective purchaser is a couple (one a registered nurse and the other a business administrator). They also own and manage another aged care facility that specialises in dementia level care. The new owners have comprehensive policies and procedures to guide staff that were developed and regularly updated by an aged care consultant. It is the new owner's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. There is a plan for the transition and change of ownership. It is intended for consistency across the two sites, they will gradually introduce their policies and procedures and quality system at Leigh Road. The prospective purchaser is not planning to make changes to management or staffing on purchase. With support by the current management team at Leigh Road, the new owner will also undertake a nurse manager 's role and will be onsite at least 2 days a week.

This audit identified that an improvement is required in relation to resident information pertaining to medical assessment records. There is an area of continuous improvement related to the physical environment which promotes safety and independence for all residents.

## **Consumer rights**

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of health and Disability Services Consumers' Rights (the Code).

The service's mission statement 'Helping people continue to live within a natural environment' promotes residents to remain active with their activities of daily living. The services are planned to respect the individual culture, values and beliefs of each resident.

There are no known barriers to Maori or residents who identify with different cultures accessing the service.

Written consents are obtained from the residents' family/whanau, enduring power of attorney (EPOA) or appointed guardians.

Residents are encouraged and supported to maintain community and family links. Families and residents interviewed expressed high satisfaction with the caring manner and respect that staff show towards each resident.

The complaints management system is clearly documented. Relatives and staff are well informed about how to raise a concern. A complaints register is available. There have been no complaint investigations by the Health and Disability Commissioner, Police, Accident Compensation Corporation (ACC) or Coroner.

## **Organisational management**

The new owners have owned and managed another facility since 2009. One of the new owner's will take on a nurse manager's role at Leigh Road but will share her time between her current facility and Leigh Road. The new owner (nurse manager) will be supported by the current management team of an assistant manager and clinical manager. The other owner will undertake a finance administrator role. The previous owners will support during and after the settlement of the business. They will be available for the next 6 months.

The organisation's vision is clearly displayed in the business plan, on the wall in the dementia service main wing and in the information booklet for families. Residents are receiving safe services that are well managed, planned and coordinated. Relatives and a few residents (due to the nature of this service) interviewed reported being very satisfied with the care and services being provided. Quality and risk management systems are coordinated by the two managers. The service is managing health and safety and risk matters in accordance with current best practice and legislation. There have been no serious adverse events. The incident/event reporting system is well established, effective and known by staff.

Recruitment, selection and management of staff meets the requirements of these standards and New Zealand legislation. An orientation programme is in place for all new staff. Records of this are maintained. All staff attend regular ongoing education and training in subject areas that are specific for full dementia care service provision and caring for the residents.

There are suitably qualified and experienced staff on site 24 hours a day seven days a week.

Consumer information is managed efficiently. Archived records are able to be retrieved if needed. Consumer information is uniquely identifiable, accurately recorded, current, confidential and accessible when required.

## **Continuum of service delivery**

A pre-admission information booklet clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents on admission to the service are admitted by a qualified and trained registered nurse and occupational therapist who completes an initial assessment and then develops, with the resident and family, care plans specific to the resident, promoting person centred care. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan. The service meets the contractual time frames for short and long term care plans. Care plans are evaluated at least six monthly.

Residents are reviewed by their general practitioner (GP) following admission. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

The occupational therapist (activities) provides activities incorporated within normal daily activities of living based on the Canadian Model of Occupational Performance and Enablement meeting the needs of residents as individuals and in group settings, the focus being the 'Spirit of the resident'. Families reported that the philosophy and activities provided are appropriate and they are encouraged to participate.

Medicine administration system was observed at the time of audit and met safe and good practice standards

The onsite kitchen caters for residents with food available 24 hours of the day, with specific dietary, likes and dislikes met. The service has a six-week rotating menu which is approved by a registered dietitian. Residents' nutritional requirements are met.

## **Safe and appropriate environment**

The facility has a current building warrant of fitness. There is an approved fire evacuation plan. Fire drills are held regularly six monthly.

Cleaning and laundry services are provided to a high standard. Chemicals are stored appropriately.

Emergency and disaster planning has been undertaken and all building regulations, fire safety, emergency and security systems are met.

The residents' families reported high satisfaction with the environment. The safety and independence of residents is maintained. Benefits and positive outcomes of new improvements in the environment has attributed to reducing residents' challenging behaviour and increased activities, independence, motivation and enjoyment of the outdoors.

## **Restraint minimisation and safe practice**

The service has a non-restraint minimisation policy. This is adhered to by staff. There were no residents using an enabler or a restraint on the day of the audit. Staff interviewed have a good understanding of the restraint minimisation and safe practice standards. Training is provided on de-escalation of situations and challenging behaviour due to the nature of this secure dementia care service.

## **Infection prevention and control**

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents.

There is a monthly surveillance programme, where infections information is collated, analysed and compared with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported and discussed at quality, staff and resident meetings.

## 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	44	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). New residents and families are provided with information about the Code on admission which is promoted in the facility's information booklet. Access to information identifying the Code was evident throughout the facility.</p> <p>On commencement of employment, staff receive induction orientation training regarding residents' rights and their implementation. Ongoing education regarding consumer rights is held and this is part of the education calendar. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights in a manner that was individual to their needs, promoting individual resident's choice.</p> <p>The prospective new co-owners understand the Consumer Rights, as they also own/manage another rest home/dementia unit within the area.</p>



<p><b>Standard 1.1.10: Informed Consent</b></p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own formal care and treatment except in the event that enduring power of attorney has been enacted.</p> <p>The residents' files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA) relating to residents' rights and the sharing of information. Advance directives are encouraged and discussed at the time of admission and signed by the resident if competent to do so. Information pertaining to informed consent is also evidenced in the information booklet. Family/whanau interviewed stated that their relatives were able to make choices around the care they received and families/whanau were actively encouraged to be involved in their relative's care and decision making.</p> <p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff demonstrated good knowledge around challenging behaviours as evidenced in progress notes, care planning and observations at the time of audit.</p>
<p><b>Standard 1.1.11: Advocacy And Support</b></p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the information provided in the information booklet. Family/whanau stated that they were encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff.</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>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities/daily programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the local shopping centre, community and volunteer groups regularly visiting the facility. Relatives interviewed stated that they always feel welcome and included in the activities occurring at the time of visiting.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures meet the requirements of the provider's contract with the DHB and Right 10 of the Code. It also contains references to advocacy and the organisation's quality system and resident's/family rights.</p> <p>Review of the complaints register and interview with the owner/manager confirmed complaints are dealt with using the internal system. There are no complaints documented in the current register. There have been no external complaint investigations. Processes are in place to ensure residents/families are advised on entry to the facility of the complaint process and the Code. The relatives interviewed demonstrated an understanding and awareness of the complaint process. Staff attend regular education on the Code of Rights, including the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admission agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed that they were very happy with the philosophy and care at the facility promoted, encouraged and provided by the staff.</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>The residents' files reviewed reflected that residents received services that were specific and individual to their independence, personal privacy, dignity and respect.</p> <p>The family/whanau members interviewed reported that their relatives were treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit with observed interactions.</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>The clinical care nurse manager (CCNM), registered nurse and caregivers interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents who affiliated with their culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. A Maori health plan was available and information was included and evidenced in the information booklet.</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>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. At the time of audit there were residents who affiliated with three different cultural backgrounds. The family/whanau interviewed reported that the staff are meeting the needs of their relatives and that their relative was treated in a manner that supported their cultural beliefs and values. This was also evidenced at the time of audit with observed interactions.</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>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries and this was evidenced at the time of audit in observed interactions between staff and residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the clinical care nurse manager, registered nurse and caregivers through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, the gerontology clinical nurse specialist and other DHB nurse specialists, consultants and allied health staff. Care guidelines are utilised as appropriate.</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit, all residents spoke and understood English. In the event of English being a second language for residents, the option of formal interpreters to support the residents and family is encouraged as required. E.g.: Hospital appointments.</p> <p>The families/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at shift handover.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	FA	<p>The overall quality and risk management documentation contains the purpose/philosophy, values and mission. There are standardised quality and risk management plan, goals and objectives. The organisation's</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>	<p>philosophy is displayed in the main wing of the facility and is documented in the service information booklet sighted. Interviews with two owner/directors revealed that the owners are closely involved with Leigh Road Cottage currently on a day to day basis. One other manager is the financial manager and advisor. An assistant manager has recently been employed and works 30 hours a week.</p> <p>There is a clinical nurse manager who is totally responsible for all clinical care and management of the residents. The clinical nurse manager is supported by two registered nurses. All three cover the on-call clinical after hours for the facility. The contracted general practitioner is also on call for the service providers for advice or to visit residents as required.</p> <p>The two owner/managers interviewed are both registered occupational therapists with current annual practising certificates. They have owned this facility for four years. The clinical care nurse manager and the registered nurse have completed interRAI training. An additional registered nurse has been interviewed (who is fully interRAI trained) to increase the level of registered nurse to three. One manager has completed the manager interRAI training.</p> <p>The service provides secure dementia care services and two rest home residents have authorisation to stay by choice at the facility but are reviewed six monthly.</p> <p>The prospective purchaser is a couple that also own and manage another aged care facility that specialises in dementia/rest home level care. They have comprehensive policies and procedures that were developed by an aged care consultant to guide staff. It is the new owner's intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. There is a plan for the transition and change of ownership. It is intended for consistency across the two sites, that they will gradually introduce their policies and procedures and quality system at Leigh road,. The prospective purchaser is not planning to make changes to staffing initially. With support by the current management team at Leigh Road (the clinical manager and assistant manager and three part time RNs), the new owner will also undertake a nurse manager 's role at least 2 days a week. The other three days the nurse manager will be based at their other facility. Advised, that the clinical and management team at Leigh</p>
---	--

		<p>Road cottage, will not be altered for at least the first 3 months.</p> <p>The new nurse manager keeps up to date with the aged care sector through regular attendance at New Zealand Aged Care provider forums and district health board forums. The new nurse manager has maintained over eight hours of professional development relating to managing aged care facilities</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The service has appropriate systems in place to ensure the day-to-day operations of the service continue should the managers` be absent. The assistant manager who is an experienced administrator/manager will be responsible for covering one or both managers when they are absent from the facility. The clinical nurse manager covers all clinical responsibilities for all residents when the managers are absent. This will remain the same with the prospective new nurse manager especially as she will only be onsite 2 days a week.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service continues to strengthen and improve its quality and risk activities. Quality and business activities are integrated and co-ordinated across all aspects of service delivery. Continuous quality improvement meetings are held monthly. Minutes of meetings reveal that quality data, such as accidents/incidents (event reporting), complaints, infection control rates, hazards, emergencies, interRAI, professional development, results from internal audits and feedback from family or staff are considered. Action plans are developed where necessary. General staff meetings are held three monthly with open discussion and an education session. Minutes of these meetings and staff education is recorded. All staff interviewed demonstrated understanding and involvement in the quality and risk system.</p> <p>Risk management and health and safety processes are clearly described. The risk management plan identifies all actual and potential business and environmental risks. The sighted hazard register is being maintained by the health and safety officer who is one of the owner/managers. The health and safety officer conducts regular environmental inspections and supports and educates staff on health</p>

		<p>and safety matters. A caregiver is being trained to assist with health and safety.</p> <p>Policies and procedures are updated as per the schedule reviewed. The policies and procedures are aligned with current good practice and service delivery and legislative requirements are acknowledged along with any other reference material used in the development of any new policies. Old records are archived and a retrieval system is in place.</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>The accident/incident policy clearly details a flow chart and forms to meet expectations. The guide to classifying consequence in incident reporting system is used for falls management. Infection control incidents are also analysed monthly along with, for example, number of falls, behaviour episodes, emotional distress, residents' absconding and/or other incidences. The adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned and untoward events on an accident/incident form. These are reported verbally at handover and in the written summary. Incidents are reviewed by the clinical nurse manager and/or management. There have been no notifiable events. Incidents are discussed at the continuous quality meetings held monthly. There was evidence in the sample of records reviewed and in interviews that staff understand and implement open disclosure practices by acknowledging and notifying events to effected parties.</p> <p>Management interviewed understood their obligation for essential reporting and notice of uncontrollable events. Notifiable pressure injuries requirements (section 31 notice) is stated in the newly implemented pressure injury policy sighted.</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>Human resources policies and guidelines for recruitment of staff management comply with legislation and good employment practices. Professional requirements are validated before commencement of employment. Copies of the registered nurses' current practising certificates were sighted. A system is in place for all other allied health professionals and the general practitioners annual practising certificates</p>

		<p>to be reviewed annually as well. New staff are being recruited according to good practice which includes formal interviews, police checking and referee checks. Evidence of this was sighted in the personnel records reviewed.</p> <p>All new staff engage in an orientation programme specific to their role. The programme includes training and competency assessments in emergency systems. A recently employed laundry assistant stated that induction and orientation was providing the necessary skills and confidence.</p> <p>Staff learning and development is planned by the managers. In-service education sessions are held regularly on a range of different topics which are scheduled over a two year period. The staff training plan is displayed in the nurses' office and in the main administration office. One of the managers is training to be the Careerforce assessor for this organisation. Staff records reviewed contained a record of the Aged Care Education (ACE) previously completed by most of the care staff inclusive of the dementia care modules. Staff records also contained a record of all other education attended. There has been good progress in engaging staff with education. The three monthly staff meetings with an education component are well attended and a record of this is maintained with the minutes of the meetings held. The two managers interviewed also meet their requirements of at least eight hours of training annually.</p> <p>All staff who are authorised to administer medicines are being competency assessed annually. All staff engage in regular performance appraisals required by the DHB contract and as part of human resources management good practice. The registered nurses also maintain their own portfolio for the Nursing Council of New Zealand. These also include infection control, restraint, wound management and medication training. The registered nurses interviewed acknowledged they attend all relevant education at the DHB as required. The clinical nurse manager is fully interRAI trained. The registered nurse is fully trained in interRAI but awaiting the final sign off.</p>
Standard 1.2.8: Service Provider Availability	FA	The service availability policy describes the service approach to staffing.



<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>The policy is aligned to this full dementia service`s philosophy. The policy is reviewed annually and when change occurs in residents, core business, goals or size. The service currently has 26 residents and works on 30 residents as two double rooms are not utilised.</p> <p>The rosters sighted reflect a higher than normal number of skilled and experienced staff on the roster to meet the needs of the maximum number of residents. The clinical nurse manager works Monday to Friday 7am to 3pm. There is registered nurse cover seven days a week 7am to 3pm. Two caregivers are on morning shift 7am to 3pm and one caregiver 7am to 1pm and an additional caregiver 10am to 6.30pm. On the afternoon shift, there are three caregivers 3pm to 11pm and one caregiver 2pm to 7pm and two caregivers 11pm to 7am on the night duty shift. There is a registered nurse on call for the afternoon and night shifts.</p> <p>The activities programme is managed by a qualified occupational therapist who implements a twenty-four hour activities programme. In addition to this, the two managers are qualified occupational therapists with current annual practising certificates. The clinical nurse manager is fully trained in interRAI and the other registered nurse is fully trained but awaiting the final sign off. The appointment of an assistant manager is very beneficial as the owner/managers also have another aged care facility (full dementia care service) to manage. The managers are available 8am to 5pm daily and after-hours as applicable for non-clinical issues/concerns.</p> <p>In 2016 the clinical care manager and the managers of this facility analysed the level of care offered to residents in terms of their level of need. The analysis evidenced that a large percentage of the residents required specialised dementia level care to manage the behavioural and psychological symptoms they were experiencing. In consultation with the DHB specialist dementia services, including Health Services for Older Adults geriatrician, specialist dementia nurse, the Mental Health Services for Older Adults team and residential needs assessment service assessors, it was more equitable and seamless for the service to transition to a full specialised dementia care service with the aim of the transition to promote quality of life for all residents. An action plan was completed with all stakeholders. The higher staff ratio has been evaluated and fully implemented. Two residents remain as rest home</p>
--	--

		<p>level of care as they individually chose to stay at this facility. They are regularly reviewed and the families are involved.</p> <p>The prospective owner confirmed on interview there are no planned changes for staff in the first three months until overall staffing is reviewed.</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 resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed.</p> <p>No personal or private resident information was observed to be on public display during the days of audit.</p> <p>All residents' files remain traceable and held within the required time frames which also encompasses the (Retention of Health information) Regulations 1996 Act. A discussion at the time of the audit was had with the clinical care nurse manager and assistant manager around the need for clearly defined summarised respite and/or long term care admission dates to be documented to minimise and avoid the risk of confusing actual admission dates and the meeting of contractual time frames with care planning documentation.</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 resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or enduring power of attorney (EPOA).</p> <p>Vacancies are updated daily through Eldernet and the facility has their</p>

		own dedicated website. When enquiries are made by prospective residents and/or their family members in or outside of normal working hours, an enquiry form is completed and the facility will also follow-up with a phone call.
<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>The facility uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, and a summary of medical notes is included. A copy of any advance directives are also included. Transfer of a resident to another facility includes notification to appropriate and required external services. Communication between the two services and with the family occurs prior to transfer and any concerns are documented. Documentation of a resident's hospital transfer was sighted during the audit and was well completed.</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>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, a process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit, no residents were self-administering medicines.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in one of two medicine trolleys found in the treatment room and nurses' office which are locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted and meets requirements. Facility and pharmacy controlled drug audits have been completed within the last six months. Medications that requires refrigeration are stored in a separate fridge.</p>

		<p>The 12 medicine charts reviewed have been reviewed by the GP every three months and this is recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. The medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.</p> <p>There are documented competencies sighted for registered staff responsible for medicine management. The registered nurses administering medicines at the time of audit demonstrated competency related to medicine management. A discussion was had with the clinical care nurse manager and registered nurse as initially when a resident required a prn medication, staff were seen to document the dosage of the medication on the non-package prn medication administration sheet (in area only left blank for name of drug), however at the time of audit the dosage was crossed out in error and signed as such. The registered nurse stated that education will be provided to all staff to avoid this occurrence happening again as seen as prescribing.</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>	FA	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed have a very good understanding of food safety management and have completed regular ongoing updated food safety training.</p> <p>There is a six-week rotating menu. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian and/or speech language specialist review as required.</p> <p>A nutritional profile is completed for each resident by the RN at the time of admission and this information is shared with the kitchen staff with a</p>

		<p>copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal and delivered to one of two dining rooms with residents having the option of trays in their rooms. Residents and families interviewed stated that there were no concerns and were appreciative of the kitchen staff who were also able to cook and provide food that was individual to their likes and needs and/or also met their cultural requirements.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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 clinical care nurse manager interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The service has implemented the electronic interRAI assessment and tools for all residents. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and include falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where</p>

		<p>a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk, dietary, weight assessments.</p> <p>The GP is required to see the resident within 48 hours of admission, however due to the isolated setting of the facility this timeframe is not always met. The majority of the residents admitted to the facility are already existing patients of the GP who supports the facility. Others are patients/residents who have been discharged from the public hospital with a formal discharge summary. The facility notifies the GP of any changes to a resident's health and/or new admissions and the resident is seen at the next weekly GP visit.</p> <p>The family/whanau interviewed reported their relative receives 'above and beyond' the care required to meet their needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Six residents' files reviewed have electronic care plans, with two of the six residents' electronic files reviewed in a draft copy. One of the six files does not evidence an initial assessment admission plan, however the clinical care nurse manager and registered nurse confirmed the care plan was completed. All other short and long term care plans were evidenced for this resident. The six files reviewed have documented short and long term care plans that address the resident's current abilities, concerns, routines, habits and level of independence and any changes implemented. Strategies for reducing and minimising risk while promoting quality of life and independence were sighted in the files. Also evidenced was the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The care staff interviewed demonstrated knowledge about the individual residents they care for.</p> <p>Residents' files reviewed focussed on client centred care (activity) therapy care plans encompassing the spirit, environment, person and occupation of the resident's current and past history. The care planning shows documented evidence of how this philosophy supports the resident and guidelines to support staff caring for the resident. The files reviewed showed input from registered nurses, health care assistants,</p>

		<p>lifestyle staff, medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication/diary book and resident's progress notes.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of the audit, the clinical care nurse manager, registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents' assessed needs and desired goals. The registered nurses and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The facility's philosophy follows the Canadian Model of Occupational Performance and Enablement. This model uses a framework focussing on person centred care empowering the 'spirit of the resident', encouraging the resident to partake in daily activities of life. The residents are also provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The occupational</p>

		<p>therapist and staff adapts their support to meet the needs and choices of the resident.</p> <p>The facility has three occupational therapists (the two owners) and one occupational therapist along with the other staff as a team promote the facility's philosophy. The occupational therapist works five days/35 hours a week and has access to other support networks within the community, nationally and internationally. The weekly activities plan/calendar sighted was developed based on the residents' needs and interests and can be easily adapted and changed depending on the residents' interest and reaction at the time promoting resident choice. The weekly schedule incorporates the above framework identifying different areas which include 'self-care, leisure and production' encouraging the staff to consider how best to encourage and/or support the resident in their daily activities of living. The occupational therapist promotes the upcoming activities on the notice boards daily through the facility and a weekly calendar of upcoming events. Regular activities include church services (group and individual visits) and included activities specific to men and women, regular visiting entertainment and volunteer/community groups and trips to other events occurring in the community and daily exercises. For residents that wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The occupational therapist, registered nurses and care givers interviewed state that they have access to activities to support residents after hours and on the weekends. A monthly newsletter is also provided and includes past and upcoming event information and is resident focused.</p> <p>The outside environment provides easy access to outside areas that enable residents to come and go safely. There are seating arrangements and different areas of focus including vegetable gardens, farm animals (chooks) and residents whom were admitted with their own animals (five small dogs in total) and are encouraged and supported to continue to care for their pets.</p> <p>The residents' files reviewed have assessments (Occupation profile/history) that have been summarised into a 'quick reference guide' that alongside the residents' daily activities of living also identify the resident's individual diversional, motivational and recreational requirements over a 24-hour period providing staff cues for residents</p>
--	--	---



		<p>whom present with challenging behaviours. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>Resident meetings are held and planning of residents' interests is discussed. Residents and staff interviewed stated that they are very happy with the activities provided and this was also evidenced in observation at the time of audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal and this was also evidenced in progress notes.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short-term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are discussed at handover; this was also evidenced at time of the audit.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</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>There is one GP who visits the residents at the facility once a week. The GP also provides a 24 hour on call after hours' service and is also supported by a locum as required. The RN or the GP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health</p>

		<p>services, general medicine services, and referrals to a psychiatrist, radiology, geriatrician, podiatry, dietitian, and speech language therapist. The GP interviewed reported that referrals to requested services are well managed from the facility and no concerns were noted.</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>	FA	<p>Policy and procedures contain correct disposal methods for all types of waste. These include standards and chemical labelling, the use of protective clothing and equipment and reporting of spills incidents. A spill kit is available. Chemical material data sheets are available and accessible for staff. The hazard register/hazardous substance register contains the chemical name, trade name, quantity, where stored, form and type and is current. Review of staff training records and interviews with the caregivers and staff who carry out cleaning and laundry duties confirmed that regular training and education on the safe and appropriate handling of waste and hazardous substances occurs.</p> <p>Visual inspection throughout the facility and observation of staff during both the audit days reveals that protective clothing and equipment (e.g., gloves, footwear, masks and aprons) is provided. All chemicals were being stored securely in a named cupboard. Chemicals are de-cantered into labelled containers. The contracted chemical supply company visits on a regular basis each month to check that staff are managing chemicals safely and efficiently and undertake the ordering and internal audit requirements of service delivery.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Hand rails are installed in corridors, showers and toilets to promote safe mobilisation and to maximise independence.</p> <p>All external areas inspected were safe, secure and contain appropriate seating and shade. The perimeter fencing is the required height and construction for a secure dementia service with a key pad gate access. Gardens are designed with the fencing taken into consideration.</p> <p>The facility is being continually maintained in good repair. Medical equipment is checked by a contracted service provider and calibrated</p>

		<p>regularly such as sphygmomanometers and scales. The service has not required a hoist. The building has a current Building Warrant of Fitness which expires 22 February 2017.</p> <p>There is a continuous improvement identified in relation to the physical environment for the positive outcomes of service improvement to the environment and the impact it has had on the residents and families.</p> <p>The prospective owner confirmed on telephone interview there are no environmental changes planned in the short to medium term plan, apart from on-going maintenance.</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>There are sufficient numbers of toilets and bathrooms for the number of residents. There is one room in the main dementia wing which has a toilet and hand basin but no shower. In the upstairs wing, there are three residents' bedrooms with a toilet and a hand basin. All other bedrooms have a hand basin. Provision is available for all staff to wash their hands within the wing and antibacterial gel is evident with adequate supplies being available. The toilets and bathrooms are in close proximity to the resident's individual rooms. All the bathrooms and toilets are maintained to a good standard, are disability accessible with easy to clean walls and floor surfaces and the showers have detachable shower heads. Hot water temperatures are being monitored monthly. Review of the monitoring records and hand testing at tap sites reveals temperatures are all below 45 degrees Celsius.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms except for two are designated as single occupancy. The two double rooms are not currently used. Screening is available in these rooms. Bedrooms are spacious and are kept clutter free. There is adequate room for those residents that require the use of a walking aide to move freely in their room and in the living areas. The service has eleven hospital beds in use. Safety is promoted at all times. Residents are encouraged to maintain independence.</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>Each of the two wings has its own lounge area as well as two large communal dining areas. The dining rooms and lounges are within easy walking distances to bedrooms. The rest home residents interviewed confirmed they use their rooms or external areas if they want privacy or a quiet time. All furniture is safe and suitable for the consumer group. The lounges are homely and decorated appropriately. One of the large dining rooms opens onto the outside large decked area. In the warmer weather, residents can choose to have a meal at the table setting on the deck. An umbrella is available for shade. The dining area up on the upper level is close to the kitchen for serving the meals. Residents are assisted at meal times as required by the caregivers.</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>	FA	<p>Designated staff cover the laundry and cleaning of the facility. The staff interviewed are allocated adequate hours seven days a week to carry out these services. The organisation conducts regular internal reviews/audits of the cleaning and laundry services to ensure these are safely and effectively managed. Where any improvements can be made, these are implemented. The contracted chemical supplier provides ongoing support and information to staff about safe handling of the products in use, and reviews the effectiveness of methods and product use. Current material data sheets about each product are located with the chemicals in the separate store cupboard on the upper level of the home. The stores sighted are adequate. The laundry staff member interviewed orders any supplies required on a two-weekly basis.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The emergency management plan complies with all applicable statutory requirements. It continues to be reviewed and improved to make it simpler and more practical.</p> <p>The service undertakes regular participation and is committed to staff training in emergency preparedness. Appropriate products and equipment are stored in readiness for any adverse event. The facility has a petrol back-up generator and a policy with instructions, and an emergency kit. Provisions include an older styled radio, mobiles, torches, a barbecue with a gas cylinder. The kitchen has gas supply. A</p>

		<p>water tank and bore is available for additional water in any emergency and for fire. The facility has back-up lighting, power and sufficient water and food, personal supplies to provide for the maximum number of residents and carers in the event of a power outage.</p> <p>The fire service approved evacuation scheme sighted is dated 29 September 2006. Fire safety drills are held six monthly. The last drill was on 31 October 2016. Records are maintained. Outcomes and learning from these exercises are documented and used for improvement.</p> <p>A nurse call system is in place in all service areas. Due to the nature of the service the call bells do not get used often but are checked on a regular basis.</p> <p>Security is provided by a contracted service provider. The staff on afternoon and night duty check the facility on a regular basis and the gates and locking systems. Any concerns, the staff contact the security staff and/or the police if required.</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>	FA	<p>The facility is heated using electric heating. These can be individually controlled in each bedroom and in the communal areas. The facility has sufficient doors and external windows for ventilation. All bedrooms have good sized external windows. The residents and relatives interviewed confirmed that internal temperatures and ventilation are comfortable during summer and winter months.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the clinical care nurse manager. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections, by using standardised definitions to identify infections, surveillance activity, noting changes in behaviours, monitoring of organisms related to antibiotic use and the</p>

		<p>monthly surveillance record. Infection control is discussed at staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.</p> <p>The clinical care nurse manager reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover, in short term care plans and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical care nurse manager has the role of infection prevention and control coordinator. Infection control issues are discussed at staff meetings. The facility has the support of a clinical specialist nurse who is available for advice on infection prevention and management. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
Standard 3.3: Policies and procedures	FA	<p>An infection control policy sets out the expectations the facility uses to</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.		minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.
<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	The registered nurse and caregivers interviewed demonstrated good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the clinical care nurse manager. Infection control in-service education/tool box sessions are held and resident education is provided, as and when appropriate.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in meetings to reduce and minimise risk and ensure residents' safety. The infection control nurse completes a monthly surveillance report. The service monitors respiratory tract infections, wounds, skin, ear, nose and throat, urinary tract infections and gastroenteritis. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings, and where appropriate, family meetings. Overall monthly statistics remain low for the facility. At the time of audit only one resident was identified as requiring antibiotics due to frequent infections. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and regular evaluations.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service restraint minimisation and safe practice policy and guideline meets the standards and the definition of an enabler is congruent with the definition in the standard.</p> <p>The service has a non-restraint policy. Due to the nature of this full</p>

		<p>dementia service there is a resident centred activities programme utilised for the twenty four hour period. For any residents with challenging behaviour, preventative activities are documented. Strategies, distractions and activities are clearly documented to guide staff. Independence is maintained. There are no residents using an enabler or a restraint on the day of the audit. No form of restraints or enablers have been used for four years. Staff interviewed have a good understanding of the standard and education is provided.</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)
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The GP on seeing the new resident completes a brief summary which is then integrated into the resident's notes, however evidence does not show a summary that includes a physical assessment of the resident and/or clarification of the resident requiring a three or one month consultation. GP documentation of resident's files audited evidenced a prior knowledge of the resident leading up to admission.	One of six residents' files did not evidence a GP summary completed by a GP on admission. Six of six residents' files did not evidence a physical assessment of the resident. Six of six residents' files did not evidence clarification of the resident requiring a three or one monthly consultation.	Ensure that a GP summary is completed for all residents when admitted to the facility which includes a physical assessment of the resident and documentation of the resident requiring a three or one monthly consultation is documented to meet the facility's policy and contractual requirements.  180 days

## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	CI	External improvements including laying of concrete at the back of Hihi wing, landscaping and installation of raised garden beds that are accessible to residents is visible. As part of the ongoing business improvement plan, management developed a plan to upgrade all external areas of the home. This is evident from the entrance to the driveway with a large facility sign being erected and the long driveway has been upgraded up to the parking area and entrance to the facility. The fencing erected is embedded amongst the garden. Large shade trees are evident with appropriate seating beneath the trees. A bokashi system with advice and guidance from the local community compost collective has resulted in this system being developed and implemented. The compost is then used for all the garden improvements such as the raised garden beds for both vegetables and flowers. A `chook	Having fully attained this criterion, the service can in addition clearly demonstrate a review process including analysis and reporting findings, evidence of action taken based on these findings, and improvements to service provision and residents safety or satisfaction as a result of a review process. As part of the ongoing business plan and with staff input the owner managers made a plan of action to upgrade the external areas of the facility. These extensive improvements have all been completed. In addition to this, and after feedback from staff that food scraps could be utilised to improve the environment, the installation of a bokashi system was implemented. Benefits and outcomes of the improvements, include improved opportunities for residents to mobilise outside the home more safely, and the associated benefits of energy use, productive living, increased Vitamin D absorption

		house` with a hand painted sign (painted by a resident and a local artist as an activity project) is enjoyed by residents and family members visiting the facility. A pathway is near completion which circles the rear of the property and back into the facility. There is also provision of dog litter bags and disposal for residents walking any of the five small dogs in the home, around the facility. This is used as an educational tool as well, for those residents with their pets living at the facility.	and management of challenging behaviours. Vegetables grown are also used in the kitchen, promoting the goal for sustainable living and enriching the lives of the residents. Feedback from relatives interviewed and satisfaction surveys evidenced positive results.
--	--	---	---

End of the report.