

# Carter Society Incorporated - Carter Court Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Carter Society Incorporated

**Premises audited:** Carter Court Rest Home

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

**Dates of audit:** Start date: 3 May 2017      End date: 4 May 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:** 40

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Carter Court Rest Home provides rest home and hospital level care for up to 41 residents. The service is operated by the Carter Society Incorporated and managed by a manager and nurse manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, members of the Executive Committee and a general practitioner.

This audit has resulted in a continuous improvement rating in falls management, health and safety and a research project involving the service's health assistants.

## 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.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent, and availability of advocacy services, is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood how to implement related policies should this be required. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.	All standards applicable to this service fully attained with some standards exceeded.
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Strategic, business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner.

On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes were identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided was of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and enrolled nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery. Staff working in the service have food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

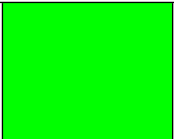
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group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

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

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

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit. The facility supports a restraint free environment. Policy and processes are in place for comprehensive assessment, approval and monitoring with regular reviews, should any enabler or restraint use be indicated. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisor and the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken. Data is analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	44	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Carter Court Rest Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including consent for photographs, outings, names on doors and the collection and sharing of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent, was defined and documented where relevant in the residents' records as relevant. Staff demonstrated their understanding by being able to explain situations when this may occur.

		Staff were observed to gain consent for day to day care on an ongoing basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service and examples of their involvement were discussed with the nurse manager.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the accredited visiting service, an Aged concern programme.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The nurse manager and the business and finance administrator are responsible for complaints management and follow up. All staff interviewed confirmed an understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.2: Consumer Rights	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through information provided as part of the

During Service Delivery Consumers are informed of their rights.		admission process, discussion with staff, and by frequent discussions on consumer rights at resident meetings. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms.
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	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, ensuring resident information is held securely and privately and exchanging verbal information. All residents have a single room.  Residents are encouraged to maintain their independence by being assisted to maintain ongoing interests, attending community activities, providing input to any arrangements required for community visits and participation in clubs or outings of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and review of training records.
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 individual and cultural, values and beliefs.	FA	Staff support the one resident in the service who identifies as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisors. Current access to resources includes the contact details of local cultural advisors. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A member of the local iwi and a kaumatua is on the Executive Committee of Carter Court. The Māori resident and the whānau reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their employment agreement. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals (for example, hospice/palliative care team, diabetes nurse specialists, the physiotherapist, wound care specialist, community dieticians, seating specialists, psychogeriatrician and mental health services for older persons), access to journal articles and education of staff. The nurse manager addresses immediately with the person concerned any practice that could compromise safety. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education, access to clinical updates and onsite education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a wide range accessible resources to ensure current best practice is maintained.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that</p>

communication.		<p>meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English or staff being able to provide interpretation as and when needed.</p> <p>Staff were observed communicating effectively with residents and family.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the Audit and Finance Committee and Executive Committee showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, occupancy and health and safety.</p> <p>The service is managed by a manager who holds relevant qualifications and has been in the role for six years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing external study and regular liaison with other managers in the sector.</p> <p>The service holds contracts with the DHB for aged residential care (both hospital and rest home level), respite, health recovery and chronic long term health conditions. 34 residents were receiving services under the rest home contract and six under the hospital level care contract at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the manager is absent, the business and finance administrator and the nurse manager together carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	CI	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections,</p>

documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		<p>and the research initiative to enhance engagement of health assistants in their daily work activity.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, health and safety and the staff meetings. Staff reported their involvement in quality and risk management activities through internal audit activities, the research project and the regular staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident meetings are held regularly with the deputy chair of the Executive Committee, where recent issues concerning food options were raised and procedures were subsequently reviewed and changed. Family satisfaction surveys are completed annually. The most recent survey showed any issues raised were followed up appropriately and actions then communicated to the families through the regular newsletter.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The health and safety policies and procedures and the work of the Health and Safety Committee have been developed to meet the requirements of ACC tertiary accreditation. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The management is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the management team and the executive committee.</p> <p>The business and administration manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. One staff related injury was recently notified to Worksafe using the appropriate process.</p>
Standard 1.2.7: Human Resource Management	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the induction and orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff members are internal assessors for the programme. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a two-week roster cycle for health assistants and a four-week cycle for RNs, confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>

<p><b>Standard 1.3.1: Entry To Services</b></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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with nurse manager. They are also provided with written information about the service and the admission process. The organisation seeks updates information for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed a co-ordinated, planned approach. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p><b>Standard 1.3.12: Medicine Management</b></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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p>

		<p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine chart.</p> <p>There were a number of residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the nurse manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders were used, were current and complied with guidelines.</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>The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in May 2016. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no</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.		longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the nurse manager. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by interRAI assessments were reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.  From May to September 2016 it was identified that the number of incident/accident forms directly relating to falls was between 50% and 84% of the total number of monthly incident/accident forms recorded. An initiative was implemented to focus on a small number of residents who continued to have frequent falls, despite conventional approaches and strategies being in place. The implementation of this initiative is identified as an area of continuous improvement.

<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 programme is provided by trained diversional therapists holding the national Certificate in Diversional Therapy, with support from two assistants and rostered volunteers.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as residents needs change and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Following an organised event, the event is evaluated by all parties involved. The residents decide whether they were satisfied or not. Results of findings are integrated into the planning of the next event. Changes are made to ongoing events as a result of the feedback received.</p> <p>Documented planning sheets, includes comprehensive assessment data recorded to identify factors to be addressed to make the event successful. Risks are identified as are the strategies to manage the risks. In the event of the diversional therapist being absent, a colleague is able to identify what is needed for the event to go ahead without her.</p> <p>The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. A recent request for bacon and eggs for breakfast and more fruit to be available has been attended to.</p> <p>Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme very diverse and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed for and progress evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 30 June 2017) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all rooms in the Bill Monk wing which have their own ensuites. Appropriately secured handrails are provided in the toilet/shower areas, and other equipment/accessories are available to</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.		promote resident independence.
Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.  There is adequate room to store mobility aids and wheel chairs around the facility. Mobility scooters are stored in an outside shed. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Large communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access a number of smaller lounge and library areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who have received appropriate training. Chemicals were stored in lockable areas and were in appropriately labelled containers.  Cleaning and laundry processes are monitored regularly through the internal audit programme and these results show consistently high results.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 29 April

emergency and security situations.		<p>2004. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 March 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, rechargeable torches, first aid supplies and gas cookers were sighted and meet the requirements for the 40 residents. Emergency lighting is regularly tested and there is access to a generator if required.</p> <p>Call bells alert staff to residents requiring assistance. The call system is monitored informally by the senior staff and residents and families reported staff do respond promptly to call bells.</p> <p>Appropriate security arrangements were in place. Doors and windows are locked at a predetermined time.</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>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by wall heaters in all residents' rooms and heat pumps and additional wall heaters in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from an external advisor. The IPC programme and manual are reviewed annually.</p> <p>The nurse manager is the designated IPC nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are tabled monthly at staff, health and safety, and quality meetings, in addition to the fortnightly management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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 IPC nurse has appropriate skills, knowledge and qualifications for the role, and has been in an IPC role for many years prior to her position at Carter Court. She has undertaken an array of training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available in addition to expert advice from a contracted advisor and the community laboratory if additional support/information is required. The nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of IPC policies and 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>Priorities for staff education are outlined in the IPC annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control nurse. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about residents remaining in their room if they are unwell and increasing fluids during hot weather.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this and management is documented in the residents' clinical records and on infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The IPC nurse reviews all reported infections. Monthly surveillance data is collated, recorded and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for any enabler and restraint management in the facility if required and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit there were no residents who were using either restraints or enablers and the facility maintains a restraint free environment.</p> <p>Restraint is only ever used as a last resort when all alternatives have been explored. This was evident from interviews with staff and the coordinator.</p>

# Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements	CI	The organisation, through the Health and Safety Committee, identified opportunities for further improvement in their health and safety practices across the organisation. The Executive Committee were then engaged in the process of quality improvement and have now all completed health and safety training from the Health and Safety (H&S) representative, including oversight of the manual and hazard management. The Committee also undertook training around all changes in regard to the Health and Safety at Work (HSAW) Act and their responsibilities as officers of the PCBU, which was undertaken by Business Central. They are now fully aware of their responsibilities as officers and all that implies. They understand their need to be fully informed of day to day H&S operations and reporting. H&S training is a formal part of the Executive Committee membership orientation and has been updated to the new legislation in the governance policy. The Health and Safety representative has undertaken training in relation to the Health and Safety at Work Act (2015) training, which has ensured an in depth understanding of all the relevant obligations and responsibilities. Subsequently new processes have been implemented for all contractors who are on site at the facility. In addition she also undertook further training in hazard management and accident investigation. The health and safety manual has been updated to reflect all changes in the HSAW Act and significant work has been completed in further developing health and safety policies and	The organisation now has a fully trained staff member on site who has undertaken significant training over and above the requirements of the new legislation. The H&S manual is fully updated in terms of the HSWA. The Executive Committee now get a copy monthly of the health & safety committee minutes with reporting on these minutes being recorded at Finance & Audit Committee meetings, a process that

of legislation, and are reviewed at regular intervals as defined by policy.		procedures.	was implemented following the changes in the Act. The service was audited by the ACC in February of this year which resulted in a marked improvement on their previous audit results and retention of their tertiary accreditation for another two years.
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>It was identified that the aged care workforce is relatively poorly paid and has a high turnover of staff, yet cares for a highly vulnerable population. A PhD research student believed understanding of the motivational factors in that workforce had the potential to improve both care and the work experience of those in this care setting. A research initiative was undertaken at Carter Court to explore motivational factors and improve understanding of how the health assistants can better engage in their work providing care for the residents, improve the quality of care and also workplace satisfaction. An advisory group of four self-selected caregivers was recruited and these staff co-designed an action plan which was implemented at the facility. The action plan has been implemented with initial work being completed and evaluated. The plan included caregiver only meetings, opportunities to learn teamwork and time management skills, task sheets, rotating rosters and leadership development. The regular meetings are well attended and a number of issues were identified with solutions suggested and implemented. These include improved shower rosters, lunchtime meal management and improved clarification of duty tasks. The findings from the implementation of the action plan indicate that the caregivers are more satisfied in their work and suggests they are achieving this by identifying issues, solving their problems and validating each other's views. This is resulting in more effective and efficient provision of care services.</p>	<p>A research initiative was implemented at the facility in November 2016 in an effort to improve caregiver satisfaction in the work place and improve the care to residents. Following the development and implementation of their action plan, which was supported by the management team, the caregiving staff have initiated a number of improvements to their daily tasks which is subsequently improving care to the residents. Staff are feeling more valued and more willing to offer suggestions on the care of residents. They are working better as a team and are more</p>

			<p>'engaged' with increased communication with managers. Staff retention will be evaluated on an ongoing basis as the initiative becomes imbedded into the business as usual process at the facility.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	CI	<p>The aim of the project was to reduce the number of falls for residents identified as continuing to have frequent falls, despite conventional approaches and strategies being in place. Initial discussions at management level identified that a member of the management team was interested in leading the initiative. Through these initial discussions and subsequent research, the following was agreed:</p> <ol style="list-style-type: none"> <li>1. To have a champion – someone to monitor and drive the initiative, report back to management and staff and to ensure that agreed practices were being incorporated in to individual resident's care plan</li> <li>2. To ensure best practice. A 'champion' joined the local DHB falls group being the only aged care representative on the group. This enabled positive sharing of information and evidenced based ideas on what was best practice. In addition, there was access to key 'experts' who could provide information and input when required.</li> <li>3. To ensure 'whole of staff' engagement in the management and monitoring of falls (nurses, home assistants, cleaning, laundry, maintenance and kitchen staff). To have regular communication, feedback processes, sharing of issues, concerns and ideas to develop further possible strategies. To do comprehensive assessment of identified high risk residents, their environment with interventions and strategies clearly identified on care plans and reviewed regularly – daily if necessary. To ensure integration of assessments by external partners such as GP and CNS health of older people.</li> <li>4. To ensure that interventions incorporated not only the resident's physical needs, but their social and emotional needs. This was to ensure the provision of person-centred care, maximise their own sense of control and wellbeing and achievement when it came to how they took care of themselves and monitored their own risk.</li> <li>5. To ensure partnership with resident and family/whanau/EPOA to enable person-centred strategies.</li> <li>6. Falls prevention is a regular agenda item for fortnightly management group meetings, monthly staff and nurses' meetings. Further discussion takes place at monthly home assistant</li> </ol>	<p>A quality initiative was implemented to focus on addressing the individualised needs of a small number of residents who continued to have frequent falls despite the use of conventional approaches and strategies. This initiative has led to a substantial reduction in falls by integrating a number of comprehensive interventions which are specific to each resident.</p>

	<p>and health and safety meetings. Results of these discussions are recorded in minutes and circulated, available to all staff.</p> <p>7. A falls register has been developed, and is maintained by the designated falls leader and updated following staff meetings or earlier if required. This register identifies high risk residents individually with monthly analysis, evaluations and results of discussions noted following meetings.</p> <p>8. Resources and information from the Wairarapa DHB Falls Prevention group is regularly disseminated for the benefit of residents, staff and families/whanau.</p> <p>9. An annual focus on falls prevention in April to align with the HQ &amp; S Commission "April Falls Month".</p> <p>10. Monthly falls statistics are collated and individual residents are evaluated and discussed with any further interventions and outcomes documented in the Falls Register and care plan</p> <p>Evaluation/Outcomes</p> <p>1. Staff have become more engaged and so better informed regarding an individual resident's risk and care.</p> <p>2. Staff have responded with initiatives for individual residents based to reduce risk and the number of falls.</p> <p>3. Because of discussion at the staff meeting, staff are more aware and engaged, and there is better monitoring of the environment.</p> <p>4. As staff are more aware of individual residents and their falls risk, changes they are more easily able to identify a potential risk i.e. a decline in health.</p> <p>5. A traffic light system of coloured stickers has been implemented on residents' files, providing to care staff a quick visual indication of each resident's falls risk.</p> <p>6. Times of falls are graphed monthly and individual trends are investigated. This has led to an increased understanding of the high-risk times of day for falls. Increased staffing hours have been implemented – a floater caregiver in the morning, and the ability to increase the caregiver hours in the evening according to identified need.</p> <p>Resident Analysis</p> <p>Resident 1, had 16 falls in last three months of 2016. Most falls occurred in the bedroom and times of falls were spread throughout 24 hours. Strategies to manage the falls were initiated after in depth analysis of the situation in addition to staff input and discussion and included contacting ACC to fund hearing aids to provide this resident with increased awareness of surroundings and potential hazards (with excellent outcome); For the first few months a sensor mat was in place to alert staff (now no longer needed); extended call bell in place to allow ease of calling for assistance.</p> <p>All these strategies were initiated because of full staff input and discussion. With staff being fully aware monitoring was vigilant and continuous.</p>	
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		<p>This resident has had no falls recorded in recent months.</p> <p>Resident 2, following admission had 26 falls recorded in the first five months. Strategies to manage the falls were initiated after in depth analysis of the situation in addition to staff input and discussion and include: the electric chair control turned off at wall when carer not present to minimise risk of tipping self out of chair due to resident pressing the chair control buttons; reassessment by diversional therapist for individualised distraction activities that are therapeutic and engage the resident; radio on preferred radio station; timely provision of extra food and fluids (resident is accustomed to frequent cups of tea) and continuing this has been of benefit; identification of cues that indicate potential restlessness. With full involvement and input from all staff this resident's falls have reduced to five falls in the last six months</p>	
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End of the report.