

# Beattie Community Trust Incorporated - Beattie 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:

<b>Legal entity:</b>	Beattie Community Trust Incorporated	
<b>Premises audited:</b>	Beattie Home	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 7 December 2017	End date: 8 December 2017
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	35	

# 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

Beattie Community Trust Incorporated operates as Beattie Home and provides rest home level care for up to 36 residents. The organisation is one of eight facilities which form the Community Trust in Aotearoa (CTCA) group. The Trust is made up of six board members and four co-opted members. The manager who is a registered nurse oversees the day to day management of the service. 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, family members, the manager, the chairman of the trust board, staff, and a general practitioner.

This audit has resulted in continuous improvement ratings related to activities, quality systems and human resources. No areas for improvement were identified.

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


Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

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

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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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 trust board, who are 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.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Access to Beattie Home is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

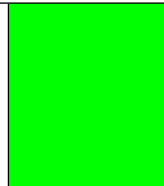
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. 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.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and medical 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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No individual resident has enablers or restraints in use at the time of audit. Environmental restraint is managed as identified in the organisation's policy and all family and residents are aware of this. A comprehensive assessment, approval and monitoring process with regular reviews

would occur should restraint be used. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, 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)
<b>Standards</b>	1	44	0	0	0	0	0
<b>Criteria</b>	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Beattie 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 understood 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. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services. Residents' meetings are facilitated by volunteers of the home.</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>	<p>FA</p>	<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. On day one of the audit six residents were out and about in the community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends, volunteers and members of the community. Family members interviewed stated they always feel welcome when they visited, included in activities occurring within the home at the time, 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>	<p>FA</p>	<p>The complaints/concerns/issues 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. Complaints forms are located throughout the facility at each entry point. The service receives many compliments, which like complaints, are also shared with staff and the board.</p> <p>The complaints register reviewed showed that one complaint has been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Follow up actions show required improvements have been made where possible. The manager is responsible for complaints management and follow up.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer areas with information on advocacy services, how to make a complaint and feedback forms at each entrance to the home.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence through community activities, arranging their own visits to the doctor, participation in clubs of their choosing and going out with family on a daily basis. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>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.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify 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. There is a current Māori health plan developed with input from cultural advisers. Eight residents affiliate with their Maori culture. Guidance on tikanga best practice is available and is supported by all staff within the home. 'Kaumatua mornings' occur on a regular basis and are organised by family/whanau and include/welcome residents from the home who affiliate with their Maori culture, their families/whanau and people from the community. Kai, waiata and the speaking of te reo Maori is encouraged and supported. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</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>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		education related to professional boundaries, expected behaviours and the Code of Conduct. All registered staff have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed, communication was excellent. Families interviewed stated that they 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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. Language and communication needs and use of alternative information and communication methods are available and used to support residents.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually at board level, outline the organisation's philosophy, values, and scope of the organisation. The nursing objectives, and business goals and objective are also reviewed and outcomes are measured at least annually. The documents described annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed adequate information to monitor performance is reported including resident movement, maintenance and property items, quality and health and safety which includes any identified risks, activities staffing, Community Trust in Aotearoa (CTCA) matters and general business. The chairman of the trust board confirmed there is excellent communication between the board and the manager.

		<p>The service is managed by a registered nurse (manager) who holds relevant qualifications and has been in the role for seven years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at seminars, clinical updates and on-line education. Education sighted covers both management and clinical aspects of the role.</p> <p>The service holds Age Related Residential Care (ARRC) and Residential Respite Services contracts with Waikato District Health Board (WDHB) and Residential Non-Aged Care with the Ministry of Health. Thirty-four residents were receiving rest home level care services under the ARRC contract and one under the respite contract. There were no residents under the non-aged contract at the time of audit.</p>
<p><b>Standard 1.2.2: Service Management</b></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 clinical aspect of the role is covered by the registered nurse (RN) with non-clinical aspects being managed by the administrator and chairman of the board. Duties are carried out under delegated authority. During absences of key clinical staff, the clinical management is overseen by the manager 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><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The use of quality improvement data has gained a continued improvement rating. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds, pressure injuries and falls. Data results are benchmarked against other members of the CTCA group.</p> <p>Key components of service delivery are incorporated into organisational goals and objectives to ensure they remain resident focused. Quality data is reviewed, trended and used to identify areas of improvement. Examples include activities for men only and ladies only which residents are very happy with. Outings for these groups include members of the local community and off duty staff and volunteers also attend. Projects put in place are well planned and implemented by all staff. For example, the falls prevention project.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the health and safety, infection control and quality meetings, staff team meetings and reported to the board monthly. Staff reported their input and involvement in quality and risk management activities through audit activities, and implementation of corrective</p>

		<p>actions and projects. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed that residents and families are satisfied with the services provided. Comments made both negative and positive were followed up by the manager. For example, one family member stated it took too long for them to be notified about an incident involving their relative. This was investigated by the manager and appropriate corrective actions have been implemented by the service.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an off-site provider and are based on best practice and were current. They are personalised to Beattie Home. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Management of policy and procedures is a dedicated role of the administrator who ensures a list of due policies are alerted to management and that only current policies and procedures are available to staff.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager and the board of trustees are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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 manager. If required, a control measure for health and safety is identified and documented on the form. These are followed up at the health and safety meeting to ensure the corrective action has been implemented and to measure the outcome of the corrective action.</p> <p>The 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. There have been no police investigations, coroner's inquests, issues based audits and any other notifications (eg, public health).</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of nine staff records reviewed confirmed the organisation's policies are being consistently implemented and records are</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff verbalised that they are 'buddied' by a senior staff member until they are comfortable in their role and that if extra time is required prior to them being included in staffing numbers on the floor this occurs. Staff records reviewed show documentation of completed orientation within one month of commencing employment. A meeting with the manager then determines any areas of specific education which are identified by the staff member and by the manager. A performance review occurs after a three-month and nine-month period. From then on annual performance appraisals are undertaken. All staff appraisals were up to date. The 2017 staff satisfaction survey identified that staff have 100% job satisfaction. This was supported during interviews with staff.</p> <p>Continuing education is planned on an annual 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. A staff member from one of the CTCA group facilities is the internal assessor for the programme. The RN is trained and competent and maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. The manager is interRAI competent for management level only. There is a RN available from one of the other CTCA facilities who assists with ensuring interRAI assessments are kept up to date when the RN is on leave.</p> <p>The service values their staff and this is documented and recorded in many various ways. Staff undertake additional education which is supported and encouraged by the organisation so that they can offer residents good quality care in all services. A continuous improvement has been given in this area.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). InterRAI information is also used to ensure appropriate staffing levels and skills mix are attained. This was confirmed in four weeks of rosters sighted. The facility adjusts staffing levels to meet the changing needs of residents. Staff verbalised occurrences when this had occurred.</p> <p>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 rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Staff cover all rostered shifts; no bureau staff are used at the facility. All staff members</p>

		<p>have a current first aid certificate.</p> <p>There is registered nurse cover on morning duty Monday to Friday and some weekends. If a registered nurse is not on duty in the weekend the shift is run by an enrolled nurse. Dedicated kitchen staff cover the kitchen duties from 7am to 7.30pm with additional kitchen staff from 6.30am to 2.30 pm. The activities coordinator works 40 hours per week Monday to Friday and care staff are specifically rostered to cover activities 9am to 3pm Saturday and Sunday.</p> <p>There are dedicated cleaning staff for 10 hours per day Monday to Friday including public holidays. Dedicated laundry staff work five hours per day, seven days a week. The manager, administrator and accounts person work Monday to Friday.</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>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. This includes interRAI assessment information entered into the Momentum electronic database. 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>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>Residents enter the service when their required level of care has been assessed and confirmed by the local Disability Support Link Assessment and Service Coordination (DSL) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from DSL and the GP 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. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</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</p>



<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information 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 appropriate documentation and communication between all parties. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The 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. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly. The last controlled drug audit was completed in November of 2017 and is completed three monthly by the pharmacist and any recommendations made at the time have been implemented.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The record 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. Standing orders are used, were current and comply with guidelines.</p> <p>There are no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>The food service is provided on site by two cooks and a dedicated kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns, is</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>also supported by Beattie Home's fruit and vegetable garden, and was last reviewed by a qualified dietitian in December of 2016.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The home has developed an approved food safety plan which is registered with the council and awaiting verification in January 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks and kitchen assistants have completed 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 was verified by resident and family interviews, satisfaction surveys and residents' 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> <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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL 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 longer suitable for the services offered, a referral for reassessment to the DSL is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale, 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 the one trained interRAI assessor on site. The RN is supported by a registered nurse who is contracted to the home to support the completion of interRAI assessments. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>Beattie Home has a goal of zero falls each month. Statistics provided show that 41 falls occurred between July 2016 and June 2017, however with specific interventions put into place for individual residents and the home as a whole, the home has recorded a reduction and identifies a total of 14 falls from June 2017 to the date of the audit. A falls audit in August 2017 identified that out of 35 residents surveyed (22 surveys were returned (63% response), eight of 22 residents had falls with four residents receiving moderate to severe injuries and six residents receiving minor injuries. Families response was 'all were satisfied to very satisfied' with feedback and service provided by staff. One family member was not satisfied with the length of time it took to advise them of a fall that occurred. The manager followed this concern with a phone call and a resolution was discussed.</p> <p>Statistics for Beattie Home showed that other than a grade one pressure injury which was identified in September 2017 and healed quickly, no other pressure area has been recorded since May 2017. A family survey in August of 2017 identified that 20 of 22 surveys were returned and showed that all family were happy with the care and communication provided by staff at Beattie Home. In summary, 12 residents had experienced a skin issue from skin grafts, abrasions, liaisons, skin tears, bruising, varicose, eczema and skin irritations. Nine residents were provided the opportunity to speak to the GP and nine family members/whanau felt 'they were well informed' and all family stated that they were 'kept well informed throughout the healing process and pain management required'.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>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 excellent. 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.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>CI</p>	<p>The activities programme is provided by an activities co-ordinator who has completed training in dementia care along with other related qualifications and is supported by 80 volunteers/friends of the</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>community who support residents and staff at Beattie Home on a daily basis to continue to be part of the community.</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 three monthly and as part of the formal six- monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include continued integration and part of normal community activities and has resulted in a continuous improvement in relation to the service delivery team approach in the way that individual, group activities and regular events are offered. Residents and families/whānau are encouraged and involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents and families interviewed confirmed they find the programmes excellent.</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. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. 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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', 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, including to mental health services for older persons and the dietician. The resident and the family/whānau 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>	<p>FA</p>	<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>	<p>FA</p>	<p>A current building warrant of fitness, expiry date 07 January 2018, was publicly displayed. The facility has a Certificate of Public Use for a new wing extension which was issued 24 May 2017. Work is to commence in March 2018 to upgrade the fire doors for this area to meet the requirements of the certificate prior to renewal. This was confirmed in documentation sighted and during interview with the chairman of the board.</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 (February 2017) and calibration of bio medical equipment (October 2017) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Easy access via ramps is in place to the grounds which have very well-maintained gardens, seating areas and appropriate shaded areas. The gardens are managed by a community group as an ongoing project.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned in a timely manner. This was confirmed in maintenance documentation sighted. Residents and families were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 15 bedrooms with full ensuites and one bedroom with a toilet ensuite only. There are separate staff and visitor toilet facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperatures are monitored and documented. They remain within safe</p>

<p>privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>temperature for residential care.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All but two bedrooms provide single accommodation. Two bedrooms have shared accommodation, one husband and wife are in one room and two cousins occupy the second double room. Where rooms are shared, approval has been sought. This was confirmed during resident interviews. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are three lounge areas, one with dining facilities at one end and another separate dining area. All of these areas are available for residents to engage in activities.</p> <p>A quiet area is available to residents and/or families (whanau room). The lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. Residents confirmed they may choose where they sit, and families confirmed privacy is never an issue.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry which is well equipped and has a very defined clean/dirty flow. Staff demonstrated a sound knowledge of the laundry processes and management of clean and dirty linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training, as confirmed during interview and in staff training records. Chemicals were stored in a lockable cupboard and were in labelled containers. Safety data sheets are available for all chemicals used.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and daily visual checks are undertaken by the manager. Any issues noted are followed up accordingly. For example, the July 2017 audit noted that the bookshelf in one area needed to be tidied up, this was followed up and re-audited by the manager as confirmed in documentation sighted.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and 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 08 November 2015 and fire equipment is checked annually in June. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 17 November 2017 with no follow up required. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Mandatory training data identifies all staff have attended a fire drill within a 12-month period.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs were sighted and meet the requirements for the 36 residents. A filtered water storage tank is located on the complex, and there is a petrol generator on site which provides up to 48 hours' emergency power. This is checked monthly as part of the regular maintenance checks undertaken. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed twice a year and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises twice nightly at random times.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and three bedrooms have doors that open onto the outside garden. Heating is provided by electric wall mounted heaters in residents' rooms and heat pumps 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</p>	<p>FA</p>	<p>Beattie Home implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from clinical nurse specialists as required. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the manager, tabled at the health and safety committee meeting and a report is provided to the board.</p>

<p>the service.</p>		<p>This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage was evident at all entrances to the facility and 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 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>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for 18 months and has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator 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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included 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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control 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</p>	<p>FA</p>	<p>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 RNs and the IPC coordinator. 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</p>



consumers.		<p>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 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 and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal tract and respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with all staff via regular monthly meetings. This information was sighted in the staff room for staff to view. Graphs are produced that identify trends for the current year and comparisons against previous years, and this is reported to the manager. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector, however in investigating the infection rates for the facility on the day of audit, it was found that the facility is over reporting and the infection rate is actually lower than that being recorded.</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 would provide support and oversight for enabler and restraint management in the facility, should they be required. The coordinator (RN) demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, no individual residents were using restraints or enablers. There is a number lock on the main front door which is identified in policy as environmental restraint for safety reasons only and families and visitors are aware of this. There are three exit doors to the outside area and only the main door has a lock on it. Resident movement is not restricted. Policy identifies that enablers are the least restrictive and used voluntarily at their request.</p> <p>The manager confirmed that restraint would only be used as a last resort when all alternatives have been explored. This was supported by a review of the restraint register, staff meetings and discussions with staff.</p>



## Specific results for criterion where corrective actions are required

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

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

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

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

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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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality improvement data are collected, analysed and evaluated. The evaluation process includes using comparative data from that previously collected and benchmarking against other members of the CTCA group. Findings are then communicated to all levels of service staff and to the board. Where appropriate, residents and family members are also informed about quality improvements that are to occur or have occurred.</p> <p>Having fully attained the criterion the service can in addition clearly demonstrate a review process, including analysis and reporting of findings with evidence of actions taken resulting in improvements to the service and/or resident satisfaction. The data sighted shows that Beattie Home has reduced their falls rate following a falls project being implemented and for two months out of 12 months there were no falls recorded. (Refer comment in standard 1.3.5). This was achieved by all staff working as a team, the introduction of strengthening and physiotherapy gym exercises, including Tai Chi, which resulted in regular, larger than usual resident numbers</p>	<p>The service can clearly demonstrate implementation of quality improvements related to achieving better quality outcomes over a 12 month period. The improvements made by the service have resulted in improved resident safety and high levels of satisfaction recorded by residents, staff and families which are measured as part of the review process.</p>

		<p>attending the daily exercise groups. New residents, including respite care residents, have safety preventions in place at the time they are admitted, helping prevent falls. Residents were kept informed of how well the falls management programme was working at monthly residents' meetings and a survey was sent to all family members asking them about how they felt the programme was working. All feedback was positive. This was confirmed in documentation sighted.</p> <p>Other quality initiatives which have resulted in measurable improvements relate to the reduction of antibiotics owing to less urinary tract infections, staff awareness and management to prevent pressure injuries, ensuring activities are meaningful to residents, such as a knitting group which continues to grow and has resulted in increased residents' comraderie and socialising, giving greater value to the outcome of their work (also refer comments in standard 1.3.7). The service has also undertaken a project to actively create staff team work, "Team Waka", by not only using a model of practice which is resident focused, but also including staff caring for each other. (Refer comments in standard 1.2.7).</p>	
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Having fully attained this criterion, Beattie Home demonstrates a review process, including measurable findings and reporting of evidence that staff education is undertaken across all areas to benefit staff skills and knowledge and therefore they are able to provide services to residents in a safer and more effective manner. This includes caregivers who have gained recognition using the pay equity scale. There are three level three, five level four and two level two staff. Fifteen staff hold full medication competencies and six caregivers can give paracetamol only.</p> <p>The service has a system in place to ensure that staff training is planned, facilitated and recorded for all staff. Beattie Home actively encourage and support staff to provide a happy and positive environment in which to work and this in turn creates a positive environment for the residents to live in. Human resources management has a clearly documented continuous improvement plan which identifies the actions taken beyond what is required in</p>	<p>There is an annual plan in place for education and also the service encourages and supports further education for staff so that their contribution to the service is maximised. This makes staff feel valued and additional duties undertaken by staff known as 'champions' is recognised by the board and management. Staff work as a team and this is reflected in staff retention, the non-use of bureau nurses as staff wish to cover each other for unexpected leave and staff members voluntary involvement in all activities both on-site and off-site when they are not on duty. Resident and family satisfaction survey results and interviews confirmed that all care is delivered in a professional, knowledgeable caring manner. Families and residents acknowledged staff efforts through</p>

		<p>the standard. Staff are valued by the organisation and this is demonstrated in meeting minutes and letters from the board sighted in staff files. The wellbeing and happiness of staff is measured by the positivity expressed by staff, and staff retention. Fourteen staff have over five years' service.</p> <p>Staff are included in decision making about how best to further improve services. Staff are nominated 'champions' in an area where they look to take extra responsibility and appropriate education is sought to ensure staff feel competent to perform the role they have nominated. For example, the maintenance person is the chemical safety champion and attends the in-service education and holds a certificate from the Employers and Manufacturers Association (EMA) related to management of hazardous substances. The activities coordinator has a degree in social policy and networks to ensure activities are very well organised and meaningful to residents, family and staff. All staff have in-depth health and safety education to ensure they maintain a safe environment for residents. There is documented evidence of all staff working as a team and management confirmed that staff always 'go the extra mile'. This was supported by resident and families interviewed during audit, in the annual satisfaction survey results and in the number of positive compliments received by the service.</p>	<p>compliments sent to the manager.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>Beattie Home has developed a resident holistic centred approach to activities which has family and the community included and part of all aspects related to the resident's day to day care. Four examples are:</p> <p>Men's Breakfast – which was developed two years ago and occurs monthly where the men of Beattie Home have 'bloke time' and go out to breakfast at local cafes with 'friends from the community'. A survey of resident and family in June of 2017, facilitated by 'friends of Beattie Home', showed all residents attending and their families were 100% happy with the planned outings and community participation.</p> <p>Knitting Club – was developed two years ago initially with four</p>	<p>Beattie Home has achieved a continuous improvement in the activities provided and integration, interaction and support of the local community. There are clearly documented findings, evidence of actions taken based on the findings and the improvements made to the service provision and resident safety and satisfaction that is measurable. This was supported during staff, resident and family interviews and in the resident/family satisfaction survey results sighted gaining an overall higher satisfaction result for care services. All benefits gained, and outcomes achieved have either a</p>

		<p>residents, now with fifteen attending knitting for the 'kids up north'. A survey of resident and family in August of 2017 facilitated by 'friends of Beattie Home' showed all residents were 100% happy with the activity and when asked, 'wanted to remain part of the group'. Staff interviewed have stated that they have noticed that one resident who was initially socially isolated has now become very active within the group, there is a general overall observation of increase in communication and discussions within the group noted, and residents are also observed to have an increase in their mobility and have more movement in their fingers and hands.</p> <p>'Kaumatua mornings' occur on a regular basis (see criterion 1.1.4) and are organised by family/whanau and include/welcome residents from the home who affiliate with their Maori culture, their families/whanau and people from the community. Kai, waiata and the speaking of te reo Maori is encouraged and supported.</p> <p>There are also eight (kindergartens through to intermediate schools) within the community who regularly visit Beattie Home and interact with residents with singing and encourage general day to day interactions.</p>	<p>resident safety or satisfaction component.</p>
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End of the report.