

Orewa Beach View Retirement Home & Hospital Limited - Orewa Beach View Retirement Home & Hospital

Introduction

This report records the results of a Surveillance 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: Orewa Beachview Retirement Home Limited

Premises audited: Orewa Secure Care

Services audited: Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 6 November 2017 End date: 7 November 2017

Proposed changes to current services (if any): There is a newly appointed experienced facility manager who was appointed two weeks ago. The Ministry of Health have been notified.

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Orewa Beachview Retirement Home and Hospital Limited - Orewa Secure Unit provides rest home and hospital level care for up to 29 residents, this includes 12 secure dementia care beds. The service is operated privately by two owner/directors. The facility is managed by an experienced registered nurse (facility manager) and a clinical manager who is also a registered nurse. The facility manager has been in the role for two weeks at the time of audit but is experienced in facility management in New Zealand. Prior to the appointment of the facility manager one of the owner/directors worked as the facility manager. Notification of the change has been notified to the Ministry of Health (MOH).

Residents and families spoke positively about the care provided.

This surveillance 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, management, staff, the gerontology nurse specialist from Waitemata District Health Board (WDHB), the visiting palliative care nurse specialist and a general practitioner.

This audit identified no areas requiring improvements.

Improvements have been made to Maori health care plans, complaints recording, business and strategic planning, formalised monthly reporting systems between the facility manager and owner/directors, and management of any temporary absence of key staff. Audits are now up to date and include pressure injuries. Policies and procedures are up to date, and evaluation and analysis

of quality data is clearly shown and communicated to staff and residents/family as appropriate. All identified deficits are managed via the corrective action process, incident and accident forms are fully completed and identify corrective actions put in place to minimise risk. New staff now complete a documented orientation/induction process and staff appraisals are up to date. All interRAI assessments are up to date and general practitioner (GP) admission timeframes are met. Residents needs are clearly shown in care planning documentation. Sharps are disposed of safely, building plant and equipment comply with legislative requirements, and six monthly fire evacuation drills are undertaken. Restraint evaluations are current. These areas were all identified in the previous audit for improvement and have now fully addressed by the service.

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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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 was no evidence of abuse, neglect or discrimination.

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 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.

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 multidisciplinary team, including a registered nurse and general practitioner or nurse practitioner, 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 and family members 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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There is a current building warrant of fitness. Electrical and medical equipment is tested as required. Toilet equipment and toilets are clean.

Oxygen is securely stored. Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised.

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. No enablers were in use at the time of audit. Two bedside rail restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. 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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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)
Standards	0	21	0	0	0	0	0
Criteria	0	44	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<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. This information, including the complaints policy, is on view and accessible to all residents and visitors.</p> <p>The complaints register reviewed showed that two complaints and two minor concerns have been received since the new owner/directors purchased the facility in June 2017. Actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. This was an area identified for improvement in the previous audit and is now fully attained by the service.</p> <p>The facility manager and the owner/director are responsible for complaints management and follow up. 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>
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	<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. The previous audit identified this</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.		area for improvement. The corrective action is now addressed with records available to demonstrate this. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. A Māori resident and their whānau interviewed reported that staff acknowledge and respected their individual cultural needs.
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 that 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 and that residents have a right to full and frank information and open disclosure from service providers. This was supported by policies and procedures that meet the requirements of the Code. Interpreter services are able to be accessed via the DHB when required. Staff knew how to do so, although reported this was rarely required due to staff who can provide interpretation as and when needed and staff also having the support of language communication cards. Staff represent many nationalities in the workplace.
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 have been updated to show the current owners goals for the organisation. The owner is aware of the need to review the goals at least annually. The business and strategic plans, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. This includes a name change to the facility and rebranding exercise to Solmar. Ministry of Health and DHB notification was made at the time of audit. The new facility manager is aware that a monthly report is required to be completed and sent to the owner/directors for review. The outline of the report required identifies that adequate information to monitor performance will be reported including occupancy, quality data results, complaints, adverse events, emerging risks and issues. Financial monitoring is undertaken by one of the owner/managers as they are an accountant. The service is managed by a facility manager/registered nurse who holds relevant qualifications from previous facility manager roles. He has been in the role for two weeks and has taken over from one of the owner/directors. There is also a clinical manager who oversees all clinical issues who is a registered nurse and has been in the role for two years. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. Both managers confirmed their knowledge of the sector, regulatory and reporting requirements and they maintain currency through on-site and off-site education in clinical and management areas. The service holds contracts with Waitemata District Health Board (WDHB) for Age Related Residential Care and

		Long-Term Support – Chronic Health Conditions Residential. Eighteen residents were receiving services under the Age Related Residential Care contract and one resident was on short term respite under the WDHB Primary Options for Acute Care at the time of audit.
<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 owner/director is absent, the facility manager has delegated authority to undertake this role. When the facility manager is absent, the clinical manager and owner/director will carry out all the required duties under delegated authority.</p> <p>During absences of key clinical staff, the clinical management is overseen by the facility manager who is a registered nurse and is experienced in the sector and able to take responsibility for any clinical issues that may arise. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The 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 resident/family satisfaction survey, monitoring of outcomes, clinical incidents including infections and medication errors, wound care and pressure injuries. Quality data is evaluated to identify trends or areas of concern.</p> <p>The audit schedule sighted is up to date and includes pressure injury management. Quality data is analysed and evaluated and results are communicated to staff, residents and families as appropriate, as confirmed in resident file reviews and meeting minutes sighted. These were areas identified for improvement in the previous audit and have been addressed by the service. Pressure injury management was audited in September 2017. A calendar has been developed to show when quality reviews, audits, staff education and safety checks are due.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, and the implementation of corrective actions.</p> <p>Staff confirmed that all quality data is shared at their monthly meetings or sooner if trending identifies areas of concern. Deficits are addressed using corrective action planning processes and actions are embedded into practice. One example sighted relates to the pressure injury management audit undertaken in September 2017 which identified that not all pressure injuries were being identified on the resident's short term care plan. Education was put in place and the re-audit of pressure injury management is due in November. The residents' files reviewed during audit showed that all short term conditions, including pressure injuries, were clearly set out on short term care plans.</p>

		<p>Resident and family satisfaction surveys were undertaken in October 2017 and will be completed annually. The October satisfaction survey results are currently being collated. No major issues were sighted in a review of the responses at the time of audit. No negative responses were voiced by either residents or families during the audit. A six weekly resident and family meeting is undertaken and they are invited to raise any concerns. This was identified in meeting minutes sighted.</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 have been personalised to the service. They are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. All policies and procedures sighted are up to date. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and all requirements have been implemented.</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 owner/director, facility manager and staff. All documentation sighted was completed to the level required to allow incident and accident data to be used as an opportunity to improve services as required. Examples sighted show that all appropriate actions were taken to manage pressure injuries, and management of falls is well documented to show appropriate use of equipment and input from specialist services as required. The resident's file reviewed showed that the fall rate has decreased from six in September to four in October. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p> <p>The facility manager and clinical manager described essential notification reporting requirements, including for pressure injuries. They advised notifications of grade three pressure injuries are notified to the Ministry of Health using the Section 31 reporting form.</p> <p>One police investigation which commenced in December 2016 remains open. This was notified to the Ministry of Health by the previous owner. The current owner/director has followed this up and is aware of actions being taken. No coroner's inquests, issues based audits and any other notifications have occurred.</p>
<p>Standard 1.2.7: Human Resource Management</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</p>

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>practising certificates (APCs), where required. All existing staff from the previous owner have been issued with new individual contracts by the current owner/directors.</p> <p>A sample of recently employed staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Existing staff annual appraisals are up to date. Staff orientation includes all necessary components relevant to the role. Staff reported that the 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. These were areas identified for improvement in the previous audit and the have been addressed by the service.</p> <p>Continuing education is planned on a bi-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. Two staff members are internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Of the 15 healthcare assistants employed currently, six are level two, one is level three and two are level four.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. All interRAI assessments were current. 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. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on-call roster is in place and staff report good access to advice when required.</p> <p>Care staff report there are adequate staff available to complete the work allocated to them. Residents interviewed supported this.</p> <p>Observation and review of four weeks rosters and interRAI level of care report identifies that all residents interRAI assessments are up to date. Staff are replaced for unplanned and planned absences. At least one staff member on each shift holds a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital. The dementia care wing duty rosters identify that there are dedicated staff across all shifts for the unit.</p> <p>The facility manager works Monday to Friday, the clinical manager works five days a week, the activities coordinator works five and a half hours five days a week, there are eight hours dedicated kitchen staff seven days a week and domestic staff work four days a week for five hours.</p>
Standard 1.3.12:	FA	The medication management policy is current and identifies all aspects of medicine management in line with the

<p>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>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 were competent to perform the function they manage. The previous audit identified an area for improvement to ensure safe medication management and disposal of sharps. The corrective action has been addressed and records were available to demonstrate this.</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.</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 stock checks by the pharmacist and RN 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 is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit.</p> <p>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>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook, 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 within the last two years. 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. The service is currently collating an approved food safety plan to present to the local council for consideration. 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. Residents in the dementia unit have access to food</p>

		<p>and fluids to meet their nutritional needs at all times. 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 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 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening 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. The previous audit identified this area for improvement. The corrective action is now addressed, and records were available to demonstrate this. The interRAI assessments are completed by one trained interRAI assessor on site who is the clinical manager with one registered nurse about to complete their training. The facility manager is also trained in interRAI, however is currently not up to date with certification in interRAI. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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 levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	FA	<p>The activities programme is provided by an activity co-ordinator. 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 reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living</p>

service.		there. Activities are offered at times when residents are most physically active and/or restless. This includes music and one to one interaction.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is 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. Families/whānau interviewed were able to provide examples of involvement in evaluation of progress and any resulting changes.</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 08 April 2018 is publicly displayed.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the owner/director and observation of the environment. All toilet equipment was clean and met infection control standards. Oxygen bottles have been secured and all efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The maintenance book identifies areas that require repairs are reported and acted upon within a reasonable time frame. These were areas identified for improvement in the previous audit and have all been addressed by the provider.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 05 September 2017. The report for the fire evacuation drill shows that this was an 'excellent' drill with all requirements met within a three-minute timeframe.</p> <p>The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and all staff have completed an emergency management questionnaire. This was an area identified for improvement in the previous audit and has been addressed by the service. Ongoing six-monthly fire evacuation drills are identified on the 2018 training calendar.</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, mouth, eye/ear/nose, gastro-intestinal track, the upper and lower respiratory tract and wounds. The IPC coordinator reviews all reported infections, and these were 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 staff via regular registered nurse and health care assistant staff meetings, at staff handovers and to the facility manager and owner/director. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked externally within an external provider.</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, who is the clinical manager, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, two residents were using bedside rail restraints. No residents were using enablers. Enablers are identified in policy as being the least restrictive and used voluntarily at the resident's request.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of files for both residents who have restraint in use showed that the individual use of restraints is reviewed and evaluated six monthly to meet policy requirements. Policy has been reviewed to show that evaluation is to occur six monthly. Family awareness and involvement in the evaluation process with the restraint process is undertaken as appropriate. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</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

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.