

Tamahere Eventide Home Trust - Atawhai Assisi Home and Hospital

Introduction

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

The audit has been conducted by 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: Tamahere Eventide Home Trust

Premises audited: Atawhai Assisi home and Hospital

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

Dates of audit: Start date: 1 March 2018 End date: 2 March 2018

Proposed changes to current services (if any): This facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards

Total beds occupied across all premises included in the audit on the first day of the audit: 83

Executive summary of the audit

Introduction

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

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

General overview of the audit

Atawhai (Mercy) Assisi Home and Hospital provides hospital and rest home level care for up to a maximum of 86 residents. A sale and purchase agreement with the prospective provider Tamahere Eventide Home Trust (TEHT), is anticipated to be settled on 29 March with takeover on 01 April 2018.

The facility is currently overseen by a full time employed manager who is experienced in managing aged care services. This person is supported by a clinical nurse manager and administration manager.

This facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards.

This provisional 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 and staff. A general practitioner interviewed, residents and their families spoke positively about the care provided.

This audit identified three areas requiring improvement. These are related to staffing, timeliness of assessments and quality review of restraint.

Consumer rights

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 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. 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

The prospective provider has a communicated plan for transition of ownership and has carried out due diligence in assessing short and long term goals for implementation. It is anticipated that aspects of the prospective provider's quality and risk management systems, and established methods for the recruitment and management of staff will be replicated at Atawhai Assisi Home and Hospital. The prospective purchaser has proven skills and experience in operating aged care services.

The current business and quality and risk management plans for Atawhai Assisi 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 identifying and delivering ongoing staff training supports safe service delivery and includes regular individual performance reviews.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, and relevant residents' records are maintained in using hard copy files.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general 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 verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and although the environment and equipment is being maintained as safe and all standards are attained, there are areas that require attention which the prospective purchase is aware of. There is a current building warrant of fitness.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible 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. Onsite cleaning and laundry services are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Staff respond to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. Ten residents were using restraints on the days of audit.

Policy is implemented related to assessment, approval and the monitoring process with regular reviews occurring. There were no enablers in use and staff understand the differences between voluntary enablers and restraint interventions for safety. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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)
Standards	0	47	0	2	1	0	0
Criteria	0	98	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility 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.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form and this was evident in all ten residents' files reviewed. Where a resident is deemed incompetent to</p>

		make an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	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 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 registered nurse provided examples of when the involvement of Advocacy Services would be encouraged or utilised.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome and included when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns. The executive manager is responsible for complaints management and follow up. Complaints are also reported at board level monthly along with a full clinical governance review being undertaken six monthly. All complaints received are entered in to the complaints register. There have been no complaints received since the previous surveillance audit in October 2017. A complaint involving multiply health care services from May 2017 continues to be investigated by the Office of the Health and Disability Commissioner (HDC). A request for more information

		<p>received from the HDC in February 2018 stated that at this time Atawhai Assisi is not the subject of that investigation. There was evidence that the service has responded in a timely way and sent the information as requested.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff. The Code is displayed in the main foyer and an information pack provided to prospective and new residents and their families includes information on advocacy and how to make a complaint. The prospective provider is an experienced aged care sector provider with a good understanding of the requirements of Code. There is an intention to focus on staff training to achieve a higher rate of staff qualifications. This will include ensuring all staff fully understand the impact of the Code on their roles.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and 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. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. There are several lounge like areas and kitchenettes throughout the facility where residents can meet with their visitors in areas other than their bedrooms. Care plans included documentation related to the resident's abilities, and strategies to maximise independence for all residents.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified,</p>

		<p>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>	FA	<p>The clinical manager interviewed stated that there is currently one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able 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 whanau. There is no specific current Māori health plan, however all values and beliefs are acknowledged and evidenced in the care plans. Information is also identified in the interRAI assessment and integrated into long-term care plans with input from cultural advisers within the local community who are able to provide guidance on tikanga best practice as required. Family members interviewed stated that they were very happy with the care provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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 residents' satisfaction survey and interviews with family and residents confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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 education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses 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.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons. A general practitioner who provide services was interviewed and confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Other examples of good practice noticed were the staff knocking on residents' doors before entering and the observation of staff encouraging and supporting residents to make day to day decisions. Family interviewed stated that they always felt welcomed by staff and included in the activities occurring at the time.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff have adapted to support residents who struggle with verbal communication and vision impairment and use simple phrases, clear direction, gestures and a tablet that the resident can easily respond to. At the time of audit, for two residents, English is their second language. Families were supported to interpret and in a more formal situation an interpreter was organised to support the resident and family member.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	<p>FA</p>	<p>Atawhai Assisi is operated by the Mercy Health Care Auckland group (a charitable trust) and managed by an executive manager who reports to</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>a seven member board.</p> <p>The executive manager holds relevant qualifications and has been in the role for nearly three years. This role is supported by the administration manager and a full time employed clinical manager. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The senior managers interviewed demonstrated knowledge of the sector, regulatory and reporting requirements and they maintain currency through regular ongoing education relevant to the roles they undertake.</p> <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. Monthly reporting to the board demonstrated that adequate information to monitor performance is reported including financial performance, occupancy, quality data results, health and safety, and emerging risks and issues.</p> <p>The service holds contracts with Waikato District Health Board (WDHB) to provide services for people requiring short term/respite care, residential aged care, and palliative care and for people with chronic health conditions. On day one of audit there were a total of 83 residents on site (three empty beds) and no residents for respite care. This included forty two residents assessed as requiring hospital level care and 40 at rest home level care under the Age Related Residential Care contract. One of the hospital level care residents is under the age of 65 years and one rest home level care resident is a boarder, funded by the clergy trust to receive personal cares and hotel services.</p> <p>Following the previous surveillance audit, 18 of the 86 beds are designated as dual purpose (for example, approved for either hospital or rest home care). One more hospital level care resident was admitted during this audit. Records show that 21 admissions have occurred since December 2017, thirteen of these are new hospital level care residents. Additional work pressures have been caused by eight deaths and one transfer during this time. There is a requirement to review the allocation of staff hours in standard 1.2.8.</p> <p>New Provider Interview February 2018:</p> <p>The new provider, Tamahere Eventide Home Trust (TEHT) is an</p>
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	<p>established New Zealand aged care provider, which has been operating in the sector since the 1960's.</p> <p>This proposed acquisition will incorporate a second facility to the current trust board business operation. There is no intention to operate a separate trust. The existing Atawhai Assisi Trust is being dissolved and the current TEHT organisational structure (as at February 2018) and its current reporting lines to the board will replace it. An additional board member will be nominated as a Catholic representative. The existing Catholic ethos will be preserved, for example the support provided by priests and nuns will remain in place.</p> <p>The CEO interviewed reports that TEHT has already increased its management level resources to enable the purchase. The existing CEO will oversee both facilities and their service provision. Other management roles such as accounting, human resources and administration back up will be provided by TEHT with staff on and off site. The proposed organisational structure is documented. A comprehensive report about the purchase has been completed. This includes the history of Atawhai Assisi, key considerations and goals for the future operations, details and reports from the property inspection with costings and timeframes for work to be completed, an overview of care services, human resources and proposed changes to electronic systems for care and medicine delivery.</p> <p>The transition plan is focused on integrating the two facilities by replicating the electronic and practical systems already in place at TEHT. It is anticipated this will occur over a six to 12 month time period. The provision of infrastructure support such as information technology capability including hardware and software, depends on the availability of fast fibre internet in the area.</p> <p>Atawhai Assisi have consulted with and informed all its current staff, residents and their families and TEHT will embark on meeting with individual staff members, residents and their families to ensure a smooth transition.</p> <p>Apart from six people who have been notified their roles will not be carried over, it is expected that the other 80 existing staff at Atawhai Assisi will transfer to the new provider.</p> <p>The prospective purchaser has notified the relevant District Health</p>
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		Board prior to the provisional audit being undertaken. This was part of a due diligence exercise undertaken since late 2017.
<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 executive manager is absent, the administration manager and clinical manager carry out the required duties under delegated authority. The clinical manager's role is substituted by one of the senior registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Interviewees stated these arrangements work well and there have been no issues. There is a requirement to review the allocation of staff hours in standard 1.2.8.</p> <p>New Provider Interview February 2018:</p> <p>The prospective provider has already confirmed staff changes and is not anticipating anymore during the transition period. They expect that the existing staffing arrangements for the day to day operations will remain in place, with easy access to the CEO, senior management staff and administrative support. The prospective new owner understands the needs of the certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 (human resources) of the agreement. The current clinical manager at Atawhai Assisi will transfer employment to the prospective employer.</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 quality and risk system reflects the principles of continuous quality improvement. This includes management of accidents and complaints, audit activities, a regular resident and relative satisfaction survey, monitoring of outcomes, and clinical incidents including infections. The quality/health and safety plan contains site specific annual goals which are reported on quarterly. Changes since the previous surveillance audit in October 2017 have been the relinquishment of external benchmarking (with QPS) and engagement with a national quality accreditation programme (EQuIP) due to costs.</p> <p>Various meeting minutes confirmed regular review and analysis of quality indicators and service performance monitoring. Health and safety, incidents and accidents, complaints and internal audit</p>

	<p>information is reported and discussed at monthly opportunity for improvement (OFI) meetings. These are attended by six management members and aspects from these meetings are reported to the board. There are also bi monthly general staff meetings, monthly RN meetings, three monthly meetings with allied service staff, and weekly clinical review meetings with the clinical care manager and the RN leaders from each wing. Meeting minutes are placed on the intranet which all staff can access. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Staff also attend annual training on the quality and risk management system (for example, reporting and management of incidents, accidents, complaints and hazards).</p> <p>There has been a focus on distributing responsibility for internal audits across all levels of staff to increase their awareness and knowledge about the expected standards. The internal audit schedule sighted covers all areas of service delivery and determines the frequency of audits. When an audit rating is below the desired outcome, remedial actions are implemented and follow up audits occur to determine the effect of actions.</p> <p>The area identified for improvement in the previous audit (evaluation of the effectiveness of corrective actions) has been fully addressed. This was evidenced in changes to the OFI meeting requirements and new processes designed to ensure that improvements identified have been implemented and then reviewed prior to the executive manager signing them off.</p> <p>Resident and family satisfaction surveys are completed on a regular ongoing basis. Information is gathered from residents' annual multidisciplinary meetings.</p> <p>The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current.</p> <p>The risk/hazard register is site specific and kept up to date with new</p>
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		<p>hazards being added as required. Management staff described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The nominated health and safety co-ordinator manager is conversant with the Health and Safety at Work Act (2015). This person facilitates regular health and safety meetings, conducts environmental audits and contributes to the orientation of new staff. The facility co-ordinator and manager and clinical manager support all staff with on the job training (such as moving and handling and de-escalation techniques) to prevent personal injury.</p> <p>New Provider Interview February 2018:</p> <p>Atawhai Assisi policies and procedures and quality systems related to hospital level care will remain in place during the transition phase. It is anticipated that TEHT policies and procedures will be introduced with full integration within 12 months. Because TEHT risk management systems are all electronic, full implementation depends on the availability of fast fibre internet in the area that Atawhai Assisi is located. The IT system will include adverse event reporting, care planning and other resident management systems. Until the electronic system is fully implemented some of the documentation may be in hard copy.</p> <p>TEHT annual quality plan now outlines the goals and objectives for takeover of Atawhai Assisi in the coming year. Their quality and performance monitoring includes conducting internal audits and implementing improvement activities and projects. Reporting against the quality and risk activities will occur monthly to the board through the operational management structure.</p> <p>The stated overall goal is to ensure Atawhai Assisi services meet best practice standards.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed (from the past three months) revealed a clear and detailed description about the incident, who was notified, who reviewed the incident and whether it required further investigation and actions. Adverse event data is collated monthly by the clinical manager, analysed for trends and reported to the executive</p>

		<p>manager who submits relevant information to the board.</p> <p>The administration manager and the clinical manager described essential notification reporting requirements. These include reporting pressure injuries and other section 31 requirements and infectious outbreaks to local public health officers. Management confirmed there have been no reports since the last audit in October 2017, including any police investigations, coroner's inquests, or issues based audits.</p> <p>New Provider Interview February 2018:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The CEO interviewed demonstrated knowledge and understanding of the actions required to meet legislative and DHB contractual requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<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. Registers of practising certificates and current first aid certificates are maintained.</p> <p>A sample of staff records reviewed contained evidence of the recruitment process, signed employment contracts, completed orientation, and annual performance appraisals. Two staff who report to the executive officer have not engaged in performance appraisals for more than two years. This includes the clinical nurse manager and the laundry leader, all other appraisals are up to date.</p> <p>Staff orientation includes all necessary components relevant to the role. New staff reported that the orientation process prepared them well for their role. A performance review with all new employees occurs three-months after commencement of work.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements and as needed education using 'toolbox' talks. Clinical staff fulfil their professional development requirements by attending education provided by the District Health</p>

		<p>Board or other external courses. There are effective systems for tracking each staff member's attendance at mandatory training, such as fire and emergency training, safe handling and transfers, and first aid and medicine competencies if that is a requirement of their role. Twenty of the 45 caregivers employed (44%) have achieved level 2 and above industry qualifications. Currently 25 caregivers are in the process of completing level three and four are in process to achieve level four. All RNs are maintaining first aid certificates and their competency for administering medicines is assessed annually.</p> <p>Four of the sixteen employed RNs (one is on extended leave) have completed interRAI training and are maintaining their competencies. The CNM is also interRAI trained but not completing assessments.</p> <p>New Provider Interview February 2018:</p> <p>The CEO interviewed stated an intention to establish a dedicated education unit on site at Atawhai Assisi, as is already in place at Tamahere Eventide Home and Village. There will be a focus on increasing staff qualifications, by replicating the training programmes that occur at Tamahere. Including the new nurse to practice programme.</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>PA Moderate</p>	<p>Atawhai Mercy Assisi Home and Hospital uses an electronic sign in and rostering system (time target) with 'templates' for allocating staff to shifts based on occupied beds.</p> <p>The current allocated staffing levels meet contractual requirements and the rosters have been adjusted to a maximum number of staff since the increase in occupied beds. The system does not appear to take into account the number of high dependency hospital level care residents that have been admitted in the past two months. For example, of the forty three residents, 22 require full support with eating and the majority require two people to assist with moving. There have been 13 admissions of hospital level care residents since December 2017. Caregivers, RNs and auxiliary interviewed were consistent in describing the workload as being too heavy and that this was unsustainable. The caregivers stated that the system of working in pairs was not always effective in spreading the workload due to variations in the physical stature and skills of some staff. There has been no injury but fewer</p>

	<p>people are offering to do additional shifts. It was noted that replacement for the unplanned absence of two caregivers in the hospital wing did not occur on Monday 26 February or the day after when one caregiver was absent. The system for finding replacement staff appears to have failed because the administration manager who authorises use of bureau staff was absent. Senior management stated that staff frequently decline to have bureau staff as replacements.</p> <p>There are also current pressures on the laundry services. (Refer to standard 1.4.6)</p> <p>In the hospital wing there are two RN's on each shift, ten caregivers in the morning, and eight in the afternoon and four at night (to cover the entire facility). The rest home has one RN allocated for the morning and afternoon, four caregivers in the morning and three in the afternoon. There is adequate provision of allied health staff (for example, cooking, cleaning, laundry and maintenance). A pool of volunteers (visitors, drivers and gardener) are managed through police vetting, induction to health and safety systems and the requirement to sign in and out when attending. The visitors assist with activities for residents and drivers for outpatient appointments. The gardener maintains all garden beds.</p> <p>Three RN's including the CNM cover a three week after hours on call roster. Staff report that quick access to advice and support is available when needed.</p> <p>Residents and family interviewed said that at certain times there were delays in staff response to call bells but that their needs were being met.</p> <p>New Provider Interview February 2018:</p> <p>TEHT adheres to a staffing policy based on the guidelines for safe staffing level and indicators. The CEO interviewed was able to confirm understanding of the required skill mix to ensure rest home and hospital/continuing care resident's needs are met. The organisation already provides a dual range of levels of care (dementia, and rest home) and recognises the competencies and contractual obligations to be met when delivering these and the additional requirement for hospital (medical/geriatric) services. The current clinical nurse manager from Atawhai Mercy Assisi Home and Hospital will be retained as will other RNs and care assistants to meet the needs and acuity of all residents. The prospective owner intends to amend the current configuration of</p>
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		primarily part time employed to full time equivalent staffing to stabilize the workforce and ensure a safe and sustainable level and skill mix.
<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>The latest archived records are held securely on site and are readily retrievable using a cataloguing system. The administrator interviewed stated that the organisation holds older records off site and in a secure building not able to be viewed at the time of audit.</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 (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 the 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 details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	Exit, discharge or transfer is managed in a planned and co-ordinated

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. 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 of a patient transferred to the local acute care facility showed the use of the 'yellow envelope' and supportive documents, communication between the facilities, family and acute hospital. 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 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 as required.</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 records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine</p>

		<p>chart. Three residents were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> <p>The prospective provider/general manager for care services interviewed stated that there is an intention to introduce an electronic system to support medicine management and to continue to use the services of the current GP service and nurse practitioner.</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 kitchen team leader and kitchen team who report to the facility co-ordinator and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns (4-week cycle supporting a nine day rotation) 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 general manager for Atawhai (Mercy) Assisi Home and Hospital interviewed stated that a food safety plan has not yet been commenced. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen team leader 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.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion with 21 residents currently requiring assistance with their meals</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. There was one example of a resident being declined to the service due to specialised equipment required and not available at the time. 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. 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, to identify any deficits and to inform care planning when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. 14 residents did not have an up to date interRAI assessment (see criterion 1.3.3.3). Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents and the outcomes of the assessment process and other relevant clinical information. This included behaviour management plans including triggers and interventions for behaviours, the support required to encourage residents to participate and continue to be part of the community, and this was integrated throughout the long-term care plan. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration, with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care</p>

		plans.
<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. One 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 service.</p>	FA	<p>The activities programme is provided by three trained diversional therapists holding the national Certificate in Diversional Therapy, an activities assistant and four activities volunteers. One of the diversional therapists is a facilitator for the Spark of Life programme. The activities staff support residents Monday to Friday from 8.30am to 4.30pm and Saturday and Sunday from 10.00pm to 2.00pm.</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 the partaking in normal community activities. Individual, group activities and regular events are offered. The activities team have developed within the facility different clubs for residents to belong to, for example poetry and choir clubs. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings which occur alternative months and residents' surveys. Residents interviewed confirmed they find the programme 'excellent' and the clubs 'fun to be a part of'.</p> <p>The prospective provider interviewed stated that there is an intention to</p>

		introduce the activities team to their facility activities staff to promote ongoing support.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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; however, not all evaluations for long term care plans were updated with the required timeframe (see criterion 1.3.3.3). 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>	FA	<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, NP (nurse practitioner) or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to physiotherapy, the hospice and to a clinical nurse specialist. 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</p>	FA	<p>There is a complete electronic register of all the chemicals being stored on site. This list details the hazardous nature and special precautions for each chemical. All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply</p>

<p>substances, generated during service delivery.</p>		<p>and manage chemicals and cleaning products and provide staff with product information. A visiting representative interviewed, confirmed that the service is adhering to safety precautions and that no adverse events related to chemicals have occurred. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</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 expiring on 22 April 2018 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists, electric beds and medical equipment occurs regularly and is scheduled to occur again on 22 March 2018. There are currently eight hoists in use. (Refer to the note in 1.4.4) The testing and tagging of electrical equipment is carried out annually by an external contractor. Maintenance staff conduct weekly checks of equipment (hoists, walkers and wheelchairs) and carry out minor repair work. There is a preventative maintenance schedule which is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said requests are actioned in a timely manner. This was confirmed by review of the maintenance request log book. The internal environment is hazard free, residents are safe and independence is promoted. Access to a glass conservatory attached to the hospital wing has been closed until structural repairs can be completed. External areas are being maintained as safe.</p> <p>New Provider Interview February 2018:</p> <p>TEHT has undertaken a period of due diligence, including building reports, in preparation for the purchase of the building and chattels. There are short term plans for building improvements such as roof replacement and any other changes to enhance the presentation and</p>

		safety of the facility and its environment. All proposed building changes require Board approval. The long term plan is to construct retirement village living on site.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. This includes forty of the 44 bedrooms in the hospital with either shared or individual ensuite bathrooms. Three bed baths are also in use. The toilet and shower facilities for rest home residents are shared, with a minimum of two bathrooms and toilets for ten residents. There are sufficient additional toilets located throughout the building and adjacent to common areas. All bathrooms and toilets have functional locking systems for privacy. Staff and visitors' toilets are separately designated. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All ablution areas are in good condition. The testing and monitoring of hot water temperatures occurs three monthly. Records show a history of temperatures being below 45 degrees Celsius.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms have a single occupant. Attention is paid to the layout of furniture in bedrooms to allow residents and staff to move around safely. Designated rest home only bedrooms are older and limited in size which restricts the positioning of their beds and the amount of personal items and furnishings that residents can bring in.</p> <p>Occupancy in some of the newer rooms with private ensuite bathrooms requires additional 'premium' charges to be paid.</p> <p>There is sufficient space in corridors and most rooms to store mobility aids and wheel chairs. Residents and family expressed satisfaction with the bedrooms.</p> <p>Prospective provider interview:</p> <p>There is an intention to install ceiling hoists in the newer hospital bedrooms to maximise staff and resident safety.</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>A number of communal areas are available throughout the facility for residents to engage in recreation, visiting or dining. There are three separate dining areas. Two in the rest home and one in the hospital wing. A large activity meeting room and separate physiotherapy gym are located centrally and are easily accessible for all residents. There are additional lounges in each wing for quiet time, privacy or visitors when required. A whanau room is available for family who are supporting unwell residents.</p> <p>Furniture is appropriate to the setting and residents' needs.</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>Designated cleaning and laundry staff are on site seven days a week. These staff have achieved qualifications in safe handling of chemicals and are provided with ongoing health and safety education from their direct report who is the health and safety officer. This was confirmed in interview with staff and review of their personnel records.</p> <p>Staff clearly described established routines for ensuring that all areas are routinely cleaned and maintained as hygienic. Site inspection revealed no concerns with cleaning. An extra cleaner is on site two days a week to carry out additional cleaning, specifically cleaning of equipment.</p> <p>Chemicals are stored securely and are decanted into clearly labelled containers.</p> <p>All the laundry is being managed on site according to known protocols for dirty/clean flow and the handling of soiled linen. During this audit, one of the two industrial washing machine had been out of order for five weeks and was still waiting for repair. It is suggested that the recent increase in demand on laundry services due to more residents on site and the impact from the loss of one machine, be taken into account when reviewing staffing hours. (Refer to corrective action in 1.2.8) Laundry staff are being remunerated for extra hours worked.</p> <p>Cleaning and laundry processes are routinely being monitored for effectiveness through resident/family surveys and via the internal audit</p>

		programme.
<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 described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan has been approved by the New Zealand Fire Service. Trial evacuation drills occur every six months, the most recent occurred on 31 October 2017. Records show 85% of staff attended at least one trial evacuation last year. The orientation programme includes fire and security training. Staff reported that a real time fire event in 2016 was effectively managed and staff responded quickly and according to procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (86). Potable water is stored in the building, and there are three 35,000 litre capacity water tanks on site. Apart from a backup battery for lighting (which is regularly tested) there are no generators on site for power outages. The protocol is to hire one.</p> <p>Call bells alert staff to residents requiring assistance. Staff were observed to respond within reasonable timeframes to these. Maintenance staff stated that the call bell system is prone to failure due to it being dependent on power cables which are regularly eaten through by rodents. There is a pest management system in place.</p> <p>Appropriate security arrangements are in place. Security patrols visit each evening, there are security stays on all windows and access into the grounds and the main entrance to the building is controlled via electric doors and gates. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	FA	<p>All rooms have natural light and opening external windows. Heating is provided via diesel and electronic wall radiators or ceiling panels with individual controls in residents' rooms and in the communal areas.</p>

ventilation, and an environment that is maintained at a safe and comfortable temperature.		Residents and families interviewed said the facilities are maintained at a comfortable temperature during all seasons.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The facility 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 the organisation's operations manager who is a registered nurse, and quality services improvement team. The infection control programme and manual are reviewed annually.</p> <p>The enrolled nurse/facility co-ordinator is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported at the monthly infection control/quality and staff meetings. This infection/quality committee includes the clinical nurse manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Staff discourage visitors from visiting the facility when unwell. 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>	FA	<p>The IPC coordinator/facility co-ordinator/enrolled nurse has appropriate skills, knowledge and qualifications for the role. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP, NP 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>
Standard 3.3: Policies and procedures	FA	The infection prevention and control policies reflect the requirements of

<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>the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2018 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 consumers.</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 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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue/wound, mouth, eye/ear/nose, gastro-intestinal tract and the respiratory tract. 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 staff meetings and at staff handovers and via access to a facility computer database. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality</p>

		<p>manager.</p> <p>Between the months of September 2017 through to and including January 2018 the facility has had a total of 51 infections. Two residents have been identified with frequent infections due to co-morbidities. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed were able to demonstrate knowledge of residents who have a high risk of infections and the interventions required.</p> <p>A summary report for a recent gastrointestinal infection outbreak that occurred in June 2017 with 15 residents and four staff affected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 CNM provides support and oversight for enabler and restraint management in the facility and demonstrated understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, 10 residents were using restraints, the majority of these being lap belts, and bed rails. One resident has a bed harness in place when in bed and another has a chair harness to enable sitting upright. A comprehensive assessment and management process is followed for the use of both enablers and restraints, which ensures the on-going safety and wellbeing of the resident.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval form in files of residents with restraints currently, and from the interview with the restraint coordinator</p> <p>New Provider Interview February 2018:</p> <p>TEHT has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. The</p>

		prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint co-ordinator, together with lead registered nurses, a general practitioner and the resident and/or family whānau, are involved in the restraint approval process. It was evident from review of restraint approval forms, residents' files and interviews with the restraint coordinator that there are clear lines of accountability, that only approved restraints/enablers are in use, and that the overall use of restraints is being monitored.</p> <p>Evidence of family/whānau/EPOA involvement in decision making, as is required by the organisation's policies and procedures, was sighted in the care plans reviewed of residents using restraints.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The initial assessment is undertaken by a registered nurse working with the restraint coordinator, together with resident's family/whānau/EPOA involvement. The restraint coordinator described the documentation process. This process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of three residents who were using a restraint. A family member confirmed their involvement in the restraint assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator and RN's review any strategies that have been implemented to actively minimise the use of restraint. Use of restraint has increased from six to ten which is related to the increase in hospital level care residents with high risk of injury from falls or fragile skin integrity. The restraint coordinator is continually reviewing how to minimise the number of restraints currently being used. For example, a recently admitted resident whose family wanted bedrails in place was</p>

		<p>assessed as being more at risk from the bedrails and use was discontinued with family participating and cooperating with the decision to cease use of bedrails.</p> <p>The restraint coordinator described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and trialling suitable alternatives, such as the use of sensor mats, before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe as per the resident's care plan. Records contain the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained, updated every month and reviewed at monthly restraint review sessions. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Training in restraint minimisation and safe use of restraints is a compulsory education requirement for all care delivery staff. .</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files confirmed the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and three monthly restraint evaluations by the restraint coordinator and general practitioner. Records confirmed family involvement in the evaluation process.</p> <p>The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved. Internal audits check if policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use</p>	<p>PA Low</p>	<p>The restraint coordinator presents a monthly report to the OFI meetings. Interview and the documentation sighted (for example OFI meeting minutes, resident files, internal audit results) revealed that although</p>

of restraint.		individual restraints are reviewed every three months and an internal audit of documentation related to restraint occurs annually, there has not been a comprehensive review that meets all the requirements of this standard. For example, review of restraint use and trends, collating of adverse events related to restraint, how decisions to remove restraint occurred and whether policy or the approach to staff education require change. An improvement is required.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Moderate	<p>Interviews with different levels of staff and review of the system for allocating staff identified that although the maximum number of staff are allocated, the workload has increased due to a significant increase in the number of hospital level care residents with high dependency needs.</p> <p>Staff stated that the system of working in pairs was not always effective in spreading the workload due to variations in the physical stature and skills of some caregivers.</p> <p>There is increased pressure on laundry staff resulting from the demands created by more residents and the failure of one of the industrial washing machines.</p>	The number of staff or hours being allocated is insufficient for the workload generated by the increase in hospital level care residents with high dependency needs.	<p>Review and adjust the allocation of staffing hours to meet the demands of additional residents with higher dependency needs.</p> <p>Ensure that absent staff are always replaced on rostered duties.</p> <p>90 days</p>
Criterion 1.3.3.3	PA Low	82 residents have individual, detailed and	Not all residents' files	Ensure that all long-term

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>client specific initial care plans and long-term care plans. Currently there are 14 residents who do not have an up to date interRAI assessment. The overdue 14 interRAI assessments were all due in February 2018. There are four registered staff interRAI trained, two of the four staff are on maternity leave with one nurse having recently returned from leave. The clinical nurse manager is interRAI trained but does not complete assessments. Staff are provided with six hours a week dedicated to interRAI.</p> <p>There are also six and three of 10 residents' files reviewed respectively that either had a long-term care plan, evaluation or an initial interRAI assessment completed; however, due to an increase in admissions and workload, the assessments have not been developed within required timeframes and were overdue between one and two weeks.</p> <p>Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided.</p>	<p>reviewed had initial long-term care plans, evaluations or interRAI provided with required timeframes.</p>	<p>care plans, evaluations and interRAI assessments are completed to meet contractual requirements and timeframes.</p> <p>180 days</p>
<p>Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint;</p>	<p>PA Low</p>	<p>All restraint activity is monitored monthly and an audit of care plans related to restraint is conducted annually but these actions are not fully meeting the intent of this standard</p>	<p>An overall review of restraint use including any positive or negative trends, staff adherence to policy and process and the effectiveness of staff education has not occurred for two years.</p>	<p>Ensure a full quality review of restraint activity (as described in the service policy) occurs at regular intervals for example six or 12 monthly depending on the extent of restraint use.</p>

<p>(c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.</p>				180 days
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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.