

Wairiver International Limited - Papakura Private Hospital

Introduction

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

The audit has been conducted by Q-Audit 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:	Wairiver International Limited
Premises audited:	Papakura Private Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 March 2018 End date: 15 March 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	45

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

Papakura Private Hospital provides rest home and hospital level for up to 46 residents. The service is operated by Wairiver International Limited and managed by a director, an administration manager and a clinical nurse coordinator. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, family, management, staff and contracted health providers and a general practitioner.

This audit has resulted in a continuous improvement in adverse event management. There are no areas requiring improvement.

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.
--	--	--

The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents and family. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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


Residents` who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Maori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are understood by staff and maintained.

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

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

The administration manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints are 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.
---	---	--

Wairiver International Limited is the governing body and is responsible for the services provided at this facility. Quality and business and risk management plans are documented and include the scope, direction, goals/objectives, values and mission statement of

the organisation. Systems are in place for monitoring the services provided, including regular monthly reporting by the administration manager to the governing body.

The facility is managed by an experienced and suitably qualified administration manager who is a registered nurse. A quality and risk management system is in place which includes an annual schedule of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction survey. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings with discussion of trends and follow-up where necessary. Meeting minutes, graphs of clinical indicators and benchmarking results are displayed. Adverse events are documented on accident/incident forms and are seen as an opportunity for improvement. Corrective action plans are being developed, implemented and monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

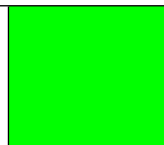
The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and staff training calendar ensures all staff are competent to undertake their role. Ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of senior staff on call out of hours.

Residents` information is accurately recorded, securely stored and is not accessible to unauthorised people. Up to date, legible and relevant residents` records are maintained in using an integrated electronic record. Back up is in place for all residents` records.

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.

The nursing staff is responsible for the development of care plans in consultation with the residents, staff and family/whanau representatives. Care plans and assessments are developed, reviewed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

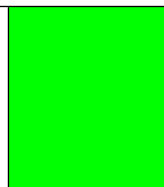
Planned activities are appropriate to the residents assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The facility is purpose built. There are single and double rooms including some with ensuite bathrooms, all of adequate size to provide personal care.


All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite, with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to emergency supplies, water, and emergency lighting is available. Security is maintained by staff.

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.
---	---	--

There is a designated restraint coordinator and restraint committee. The use of restraint is minimised. Enablers are used on a voluntary basis. All restraint and enabler use is assessed, approved and monitored. There were 11 residents on restraint and 14 residents using enablers. Staff receive ongoing education and maintain their competencies. Policies and procedures on restraint and enabler use are current.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control management systems are in place to minimise the risk of infection to residents, visitors and service providers. The infection control coordinator is responsible for coordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. Three monthly benchmarking is conducted by an external provider. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	50	0	0	0	0	0
Criteria	1	100	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
<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 service has developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Care and management staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training is included on the Code of Rights as part of the induction process for all new staff and is ongoing, as was verified in the training records during the audit.</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>A detailed informed consent policy is available. The service ensures informed consent is part of all care plans and contact with families and residents was verified in the records reviewed. Every resident has the choice to receive services, refuse services and withdraw consent for services. Informed consent is closely linked with the residents' Code of Rights and Responsibilities.</p> <p>The service provider ensures residents/family enduring power of attorney (EPOA) understand documents that they are signing when English is not their first language. An interpreter is used as required. The informed consent forms, resuscitation and advance care instructions, and flu vaccine consents sighted are available in English. The staff interviewed demonstrated their ability to provide information that residents required in order for the residents to be actively involved in their care and decision-making. Staff interviewed acknowledged the resident's right to make choices based on</p>

		information presented to them. Consent was sought for transportation and was sighted on the activities forms, residents care plans and verified by residents and family interviewed.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Nationwide Advocacy Service. Posters related to the Nationwide Advocacy Service are displayed in the facility, and additional brochures available at reception. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and education was provided as evidenced in the education plan and staff records reviewed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending outings, activities and entertainment. Visitors are welcome and the facility has unrestricted visiting hours. Family members stated they felt welcome when they visit and comfortable in their dealings with staff.</p> <p>Residents records reviewed evidenced links in the community with residents attending aged concern, stroke foundation, return services association (RSA) meetings as part of the activities programme. Staff and/or family assist residents to attend these activities, interests as much as possible.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy details the resident, staff, visitors and family member`s right to make a complaint. The process for reporting, investigating, documenting and following up the complaint is documented and the timeframes align with the requirements of the Code.</p> <p>The administration manager and the director interviewed advised there have been no complaints received from the Health and Disability Commissioner (HDC), Ministry of Health (MoH), police, coroner and/or ACC since the previous audit. A complaints register is maintained. A review of the complaints documentation verified the complaints have been investigated and responded to in a timely manner. Four complaints were recorded since the last audit and a recent complaints is still open.</p> <p>All the residents and family members interviewed confirmed being aware of the complaints process. The residents and family identified they were happy with the services provided.</p> <p>The staff interviewed were able to detail their responsibilities in the event a resident made a</p>

		complaint.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the administration manager as part of the admission information provided and discussion with a registered nurse on admission during the assessment process. The Code is displayed in the entrance way together with information on advocacy services and how to make a complaint feedback forms. A suggestion box is also available in the entranceway.</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 interviewed confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Families reported there was always a positive atmosphere when they visit.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (e.g. when attending the personal cares, ensuring residents information is held securely and privately). Any exchange of verbal information is managed so that others cannot hear. All residents have their own rooms. There is one double room with one resident in the room. Curtain screening is available should there be two people in the shared room.</p> <p>Residents are encouraged to maintain their independence by going on outings with family in the community, shopping trips, community activities and attending activities of their choice. Each care plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual culture, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviewed understood the service's policy on abuse and neglect, including the signs and symptoms, and what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for all new staff, and is then provided annually, as confirmed in the training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori</p>	FA	<p>The policies reviewed acknowledge the organisation's responsibilities to Maori in accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers as part of</p>

<p>have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>the organisation`s objectives which are documented in the Maori Health Plan.</p> <p>There were 12 residents who identified as Maori at the time of the audit and 10 staff who identified as Maori. The healthcare assistants (HCA) interviewed demonstrated good understanding of services that are in line with the needs of Maori residents and the importance of whanau. Tikanga principles are understood by staff.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident`s personal preferences, requiring interventions and special needs were included in all care plans reviewed.</p> <p>Staff interviewed reported they received training in cultural awareness and this was evidenced in the education plan reviewed.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The general practitioner interviewed also expressed satisfaction with the standard of services provided to the residents. The staff records reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. The family and residents reported they are happy with the care provided. The clinical nurse coordinator, registered nurses and enrolled nurses interviewed have completed the New Zealand Nursing Council professional boundaries workshops which is mandatory for obtaining an annual practising certificate.</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 allied health professionals, gerontology nurse specialists from the DHB, and services for older people visit the facility regularly. Registered nurses attend ongoing education externally at the DHB as able.</p> <p>The general practitioner confirmed the service seeks prompt and appropriate medical intervention when required and are responsive to medical requests.</p> <p>Staff reported they receive in-service education on a regular basis. The clinical nurse coordinator and registered nurses interviewed stated that the support of management was appreciated for external education opportunities to support contemporary good practice.</p> <p>The organisation has attained an area of continuous improvement for the management of accidents / incidents and the reporting of adverse events inclusive of essential notification reporting to the</p>

		appropriate agencies involved.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative`s health 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 resident`s records reviewed. There was also evidence of resident/family input into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> <p>Interpreter services are available and accessible via the DHB if and when required. Staff know how to do so, although reported this was rarely required due to staff (multicultural representation) being able to provide interpretation as and when needed and the use of family members.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Papakura Private Hospital has a documented mission statement and philosophy on care that is focused around the provision of individualised, resident focused care that maximises independence. The administration manager (AM) monitors the progress in achieving goals via the internal audit process at the monthly quality meetings. The AM has an `open door` for residents and families. The quality/business plan was reviewed for 2018. A number of goals/objectives are set for the forthcoming year and these are monitored and documented once completed.</p> <p>The day-to-day operations and ensuring the wellbeing of residents is the responsibility of the AM who has worked at this facility since 1990. The AM is a registered nurse who is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The AM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency by attending management related education annually.</p> <p>The AM is supported by the clinical nurse coordinator (CNC), an experienced registered nurse. Each have allocated responsibilities and goals to achieve as set out in the business plan. The management team consists of four managers and three were interviewed during this audit. The new owners took over the lease of this facility 1 June 2017. One owner director is involved with the day to day management and the other director is responsible for the hospital intranet being currently set up and all technology aspects of the business.</p> <p>The service holds contracts with the DHB for rest home (RH), respite care, younger persons disabled (YPD), long term chronic (LTC), accident compensation corporation (ACC) and hospital level care. Forty five residents received services under the contracts on the days of the audit: one rest home,</p>

		one respite care, seven YPD, seven LTC, two ACC and twenty seven hospital level care.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical nurse coordinator is responsible for oversight of all services in the administration manager's absence and is on site weekdays. The CNC is experienced in aged care (owner of this facility which is now leased to current directors) and has been at this facility for 20 years.</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>There is a quality and risk plan and this was sighted. Policies and procedures are available to guide staff practice. The policies are developed, authorised by the AM, implemented and reviewed regularly as per the documented review schedule. Policies and procedures are currently being changed over to an electronic system but hard copy master manuals are still available. Out of date policies are archived. Policies and procedures are developed and implemented to guide staff with appropriate references to interRAI being included to guide staff. InterRAI assessments are current and up to date for all residents.</p> <p>A review of the quality and risk programme is undertaken three monthly. The minutes of meetings were reviewed and included in discussions on individual resident's needs, complaints and compliments, by changes to policies/procedures/practices, the results of audits, staffing, education, the use of restraint, infection data and for all types of incidents and quality related trends. The management team and the director have an 'open door' to staff and residents/families. This was verified by residents and family interviewed.</p> <p>Internal audits have been undertaken and are conducted using template audit forms. A schedule of what audits are to be undertaken and when. Audits sampled during the audit identified there is good compliance by staff in meeting the requirements of the organisation's policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored. Short term care plans are utilised to document follow-up for applicable incidents (e.g. falls management).</p> <p>An annual resident satisfaction survey is performed. The feedback is predominantly positive about the services provided. Staff have responded to any individual specific requests/comments raised by residents. The service provides a diverse range of services at this private hospital care setting.</p> <p>Resident meetings are held and minutes sighted reflected discussion on food, the activities</p>

		<p>programme, staff, laundry services and facility cleanliness. Resident compliments were recorded and communicated to staff. Education has been provided to residents on infection prevention and control topics during the resident meetings as needed.</p> <p>A risk management plan is in place. Organisation risks are categorised, documented and mitigation strategies noted. The AM and the CNC were able to discuss changes in organisation risk. Whilst new hazards are being reported, the hazard register was dated as last reviewed January 2018.</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>Policy and procedures detail the required process for reporting incidents and accidents. Different template forms are used by staff to report events including infections, episodes of challenging behaviour, medicine related errors and incidents and accidents. Staff are provided with education on the responsibilities for reporting and management of accidents and incidents during their orientation and as a component of the ongoing education programme and as discussions at staff meetings.</p> <p>Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This was verified by residents and family members interviewed. The incident form includes an area to record that family were informed and who else was notified about the reported event (e.g. where applicable the RN, CNC and the resident's GP). A summary of the number and type of reported events is maintained by the CNC. A review of reportable events demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident's care plan where applicable or a short term care plan developed. Staff communicated incidents and events to oncoming staff via the shift hand over. Individual events are discussed with staff monthly, at the staff meetings and also reviewed at the service review meetings that are held three monthly. Themes and trends are monitored and evaluated.</p> <p>There is an area of continuous improvement identified linked to adverse event reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The copy of the annual practising certificates (APCs) for all health professionals involved with this organisation were sighted and were current.</p> <p>The recruitment policy aligns with current good practices. This includes staff completing an application form and completing a health declaration, police vetting, interviews being conducted and reference checks obtained and retained. Staff have assigned employment agreement and confidentiality/privacy agreement on file. Performance appraisals are conducted at least annually and these were sighted in relevant staff records reviewed.</p> <p>Records evidencing completion of the orientation programme were present in staff records. Staff</p>

		<p>interviewed report the orientation included being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident's care needs.</p> <p>The 2018 in-service education calendar was reviewed. Individual records of education are maintained for each staff member and copies of education certificates are present in the staff files reviewed. In-service education and attendance records were sighted showing staff had access to regular ongoing education relevant to their roles. There was good attendance from staff at the in-service education sessions provided.</p> <p>There are three registered nurses who have completed the interRAI training and annual competencies are maintained. There is one registered nurse currently training and is near completion of the course.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with the DHB. The AM is on site four days a week. The director is available Monday to Friday for day to day operational requirements.</p> <p>The last two months and the current roster were reviewed and demonstrated that all three wards have appropriate staff cover to meet the complex and diverse needs of residents in this specialised aged residential care facility, providing private hospital level care for all but one resident who is assessed as rest home level care. The CNC oversees all wards three days per week. The roster is displayed daily on a whiteboard near the nurses' station. In addition to registered nurses and care staff there are three cleaners, one laundry person, one cook, a kitchen hand, two maintenance persons and activities personal. All staff interviewed report that there is adequate staff available and additional staff are provided if and when necessary. There is a clinical on-call system for the after-hours, with the CNC and the AM taking week about to cover the service.</p> <p>Residents and family members interviewed confirmed staffing meets their needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information was fully completed in the residents' records sampled for review. Clinical notes were current and integrated with general practitioners and allied health service providers notes. Records were legible with the name and designation of the person making the entry identifiable. A hard copy and electronic back up system is available for the resident records.</p> <p>Archive records are held securely on site and are readily retrievable. Resident' records are held for the required period before being disposed of appropriately. No personal or private resident</p>

		<p>information was on public display during the audit.</p> <p>Information is accurately entered into the notes to the assessment on Momentum (the interRAI software programme). This includes entering other assessments results that have been clinically indicated. The assessment summary including triggers and outcome scores are evident in the resident records reviewed and are addressed as required in the care plan.</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>Papakura Private Hospital's welcome pack contains information about entry to service and a client admission enquiry details form is completed. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medication entries sampled on the electronic system complied with current legislation, protocols and guidelines. Medications are stored in a safe and secure way in the locked drug trolley and cupboards. Medication reconciliation is conducted by the RNs when the residents are transferred back to service. The service uses the electronic system for e-prescribing, ordering, dispensing and administration and is accessed by use of individual passwords. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification.</p> <p>The controlled drug register is current and weekly and six-monthly stock takes are completed and all medications are stored appropriately. There were no expired medications that needed to be returned to the pharmacy.</p> <p>An annual medication competency is completed for all staff administering medications and</p>

		<p>medication training records were sighted. The RN was observed administering medication correctly.</p> <p>There were no residents self-administering medication at the time of the audit and there is a policy and procedure for self-administration of medication if required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. A client food preference sheet is developed on admission which identifies dietary requirements, likes and dislikes. Supplements are provided to residents with identified weight loss issues. A daily evening meal order sheet is completed for individual residents' preferred choices. Face to face communication with the residents is conducted by the cook to find out their food preferences and this has resulted in the reduction of food complaints. Care staff complete a percentage intake form that indicate resident's food intake at each meal.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p> <p>In interviews, residents and family/whanau expressed satisfaction with the food service.</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>	FA	<p>The clinical nurse coordinator reported that whenever a consumer is declined entry, family/whanau are informed of the reason for this and other options or alternative services available and this is indicated on the consumer admission enquiry details form. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>The initial assessments are completed within the required time frame on admission, while care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews</p>

manner.		conducted family/whanau expressed satisfaction with the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to initiate care plans and short- term care plans for acute needs. Goals are relevant and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
<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	The documented interventions in short term care plans and long term care plans are adequate to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Electronic progress notes are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed and the staff confirmed they have access to the supplies and products they needed.
<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 planned activities are meaningful to the residents' needs and abilities at Papakura Private Hospital. The activities programme covers physical, social, recreational, spiritual, intellectual emotional and cultural needs of the residents. The activities coordinator reported that they establish the residents' responses and interests during activities and modify activities accordingly with oversight from the clinical nurse coordinator. Residents' electronic files have a documented activity plan that reflects their preferred activities of choice.</p> <p>The activities coordinator develops a monthly and weekly activity planner which is posted on the respective notice boards. Activities are provided for all residents' in rest home, hospital and under 65 years of age. Individualised and group activities are conducted for long term and YPD residents. These include van outings, group discussions, animal therapy, word building, quiz, bible reading, exercises, art and craft. Daily activity attendance record is completed and one on one sessions conducted to capture those reported absent. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>InterRai assessments, care plans and activity plans are evaluated/reviewed in a comprehensive and timely manner. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau, residents and staff input is obtained in all aspects of care and care plans are reviewed/evaluated accordingly. Short term care plans are developed as per rising need. All care plans sampled were updated and reviewed every three and six months or as required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the RNs or the GP.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place. The doors to the areas where chemicals are secured and all containers are clearly labelled. Appropriate signage (chemicals/hazards) is displayed where necessary. The two maintenance persons interviewed are responsible stored and supplies are maintained. Both have received training in safe handling of chemicals. An external company is contracted to supply and manage chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Two spills kits are readily available. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including gloves, aprons and hats.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>A current building warrant of fitness expires 28 July 2018 and is publically displayed. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interview</p>

<p>for their purpose.</p>		<p>with one of the maintenance personnel and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, shared bathrooms between two rooms and communal bathrooms. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Since the previous audit individual vanities have been replaced with a more streamline variety which take up less space in the individual rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within the bedrooms safely. Residents' bedrooms provided single accommodation, except for eight shared rooms. Privacy is maintained in the shared rooms with curtain screening being available. Rooms are personalised with furnishings, photographs and other personal items displayed. As rooms are vacated they are being painted and refurbished with curtains and new floor coverings.</p> <p>There is room to store mobility aids, walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms. Mobility wheelchairs are stored in a designated area (batteries can be charged up a night) and do not impede walkways or create a hazard for mobile residents.</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</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enables residents to move freely if able. Since the last audit all living areas and hallways have been painted and this has lightened and freshened the facility significantly.</p>

needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in a dedicated laundry. Residents' personal items are laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Care and laundry staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen.</p> <p>There is small designated cleaning team who have received appropriate training. Chemicals and other resources are stored in two lockable cupboards with key pad access. Chemicals in use are clearly labelled and a refillable pump system is used. Cleaning and laundry processes are monitored through the internal audit programme.</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 procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides, direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 20 February 1999. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas barbecue were sighted and meet the requirements for a maximum of 46 residents. A water storage tank holding 2000 gallons of water is available. There is no generator on site but one can be hired if required. Emergency lighting is available and is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells and this was observed during the audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked and checked regularly after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that</p>	FA	<p>All residents' rooms and communal areas have opening external windows. Ceiling heating and heat pumps provide adequate heating throughout the facility and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facility and individual wards are maintained at a comfortable temperature.</p>

<p>is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Papakura Private Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The clinical nurse coordinator is the infection control coordinator (ICC) and has access to external specialist advice from a GP, External consultant and DHB infection control specialists when required. A documented job description for the ICC including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and electronic progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are</p>	<p>FA</p>	<p>The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	Staff education on infection prevention and control is conducted by the ICC. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP; laboratories; External consultant and local district health boards. Staff interviewed confirmed an understanding on how to implement infection prevention and control activities into their everyday practice.
<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	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The assessment, approval, monitoring and review process is the same for both restraints and enablers. An updated restraint register was sighted and staff interviewed understand the difference between restraint and enablers. Risk minimisation is documented in the care plans of the residents and restraint is evaluated regularly. Approved equipment which can be used as a restraint includes, bedrails and soft body harness. There are currently 11 residents on restraint and 14 residents using enablers for safety and comfort. The family and residents are fully informed about the restraint process and risks involved.</p> <p>All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.</p>
<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</p>	FA	The clinical nurse coordinator is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes: the clinical nurse coordinator, GP, physiotherapist and a family representative. Restraint use is

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		discussed in management and staff meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint assessment process is fully documented and includes the requirements of this standard. Residents' records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the resident (or family), the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records sampled is for safety reasons.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	All restraints are used as a last resort. Discussions regarding trialled alternatives were sighted in records sampled. Once in place, restraints are monitored for safety. Bed rails have protective covers. All residents on a restraint are monitored every two hours. There have been no reported incidents related to unsafe restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Regular reviews are conducted on residents with restraints and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long term care plans. Evaluations time frames are determined by the risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service has demonstrated monitoring and quality review on the use of restraints. Restraint updates are included in the monthly staff meetings and continuous quality improvement summary reports. Individual approved restraints are evaluated three monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. The clinical nurse coordinator reported that assessments and monitoring are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are done.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the</p>	CI	<p>The AM was interviewed and had a good understanding of regulatory obligations in relation to essential notifications. Issues were raised when a series of significant incidents / adverse events occurred at this facility. This was a learning experience for the AM and for ARRC agencies involved. A resident was admitted for hospital level long term care. Two months later the resident was interRAI re-assessed for rest home level care. After several major incidents and challenging behaviour episodes (incident forms were completed) which were managed well by staff. Contact was made with an advocacy service on behalf of the resident. The resident was referred to mental health services for older people and provision was made for the resident to transfer to another facility. Further disruptive incidents involving the NZ Police occurred and the DHB locality manager was contacted and a Section 21 notice of termination of care was to become effective the next day. The notice was served by the AM and a witness was present. The resident refused to sign the document. Formal notification was made to the appropriate agencies. The resident left the facility again, and was returned by NZ Police as the resident was still within the 21 day notice. Charges were laid by the police to the resident for several incidents that occurred, one of which involved hospital staff. Lawyers were involved. A section 31 notice was sent to HealthCERT. The resident had previously been referred and seen by a DHB Geriatrician and was assessed as being fully independent and not eligible for a residential care</p>	<p>Having fully attained the criterion, can in addition clearly demonstrate a review and analysis process of incidents and accidents to ensure appropriate corrective action planning has been undertaken to improve safety and care delivery for residents. The outcome was only</p>

<p>correct authority is notified where required.</p>		<p>subsidy. Nine days after the 21 day termination of care notice was enforced a `Trespass Notice` was issued by the Police. All parties were notified by email and family by phone. The action taken was an example of how an interRAI re-assessment was used to aid the discharge of a resident for safety reasons from residential care, when a number of issues relating to challenging behaviour escalated. The resident was safely removed from the facility.</p>	<p>possible with the considerable support and back up in collaboration with the service, the DHB and other appropriate agencies being notified where and when required.</p>
--	--	---	---

End of the report.