Elsdon Enterprises Limited - Annaliese Haven Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Elsdon Enterprises Limited
Premises audited:	Annaliese Haven Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 May 2018 End date: 3 May 2018

Proposed changes to current services (if any): The reconfiguration of beds, which increased rest home bed numbers by 11 from 20 to 31, and reduced dementia beds by 13 from 43 to 30 (August 2017) was reviewed during this audit. With the removal of two rooms for other purposes, total bed numbers reduced from 63 to 61.

A dispensation in place (May 2017) is no longer applicable as the person has since deceased.

Total beds occupied across all premises included in the audit on the first day of the audit: 56

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

Annaliese Haven Rest Home provides rest home and dementia level care for up to 61 residents. The service is operated by Elsdon Enterprises Limited and managed by a facility manager and a clinical nurse manager. Since the last audit the configuration of beds has changed with the service provider now having 31 beds available for rest home care and 30 for dementia services, 56 of which were occupied on the day of audit.

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

Residents and families spoke positively about the care provided and consistently fed back how much this service has improved over the past 18 months to two years.

The audit has resulted in acknowledging continuous improvements for four criteria of two standards. These relate to overall service delivery and the activity programme. There were no areas identified as requiring corrective action.

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.

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

Open communication between staff, residents, and families is promoted and was confirmed to be effective. Interpreting services are accessible if required. Staff provide residents and families with the information they need to make informed choices and give consent. Verbal and written informed consent processes are in place, as are those for relevant advance care planning.

Residents who identify as Māori have their needs met according to the Māori Health Plan policies and procedures in a way 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 practise and meet residents' needs.

Complaints are managed according to policy and procedures with investigation and follow-up occurring. A complaints register is being used.

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.

Business and quality and risk management plans include the scope, mission statement, motto, values and objectives of this service provider, all of which are resident focused. The governing body receives regular reports, which demonstrate ongoing monitoring of the service is occurring. An experienced and suitably qualified person manages the facility alongside an experienced registered nurse.

The quality and risk management system includes the collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. 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.

Managers are aware of reporting requirements for significant events and adverse events are documented with corrective actions implemented as relevant.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training for staff at all levels supports safe service delivery. Annual individual staff performance reviews are occurring.

There are adequate staff being rostered to meet residents' needs and the skill mix enables staff to spend time with residents at an individual level.

Residents' information is being managed according to legislative requirements with accurate recordings documented, secure storage systems and unauthorised people do not have access to it.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family. All new residents are required to have a completed needs assessment prior to entry.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. InterRAI assessments and re-assessments were up to date.

Short and long-term care plans were 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.

A planned activity programme provides residents with a variety of individual and group activities and enables residents to maintain their links with the community. Every effort is made to follow personal preferences.

The medicine management system is being implemented according to policies and procedures and meets requirements. Medicines are administered by staff who are competent to do so.

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

Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested according to requirements. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. At the time of the audit there were no restraints or enablers in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler process.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and 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 by regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken 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	2	43	0	0	0	0	0
Criteria	4	89	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Annaliese Haven Rest Home (Annaliese Haven) 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 could name the different rights and how they would apply them in their work day. Staff were observed treating the residents in a polite and respectful manner, calling residents by preferred names and giving options as well as maintaining the residents' dignity and privacy. Training is included in the orientation process and then annual updates were verified through training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent policies and procedures provide staff with guidance on verbal, gesture and written consent processes. Nursing and care staff interviewed understood the principles and practice of informed consent. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Evidence of medical practitioner assessment of each resident's competence for making decisions regarding resuscitation and advance care planning, for example, was also evident. Processes for residents unable to consent are defined and relevant documentation is in each resident's record. All except one of the residents' files that were reviewed had Enduring Power of Attorney documentation in place. The missing one was for a rest home resident and this is reportedly currently being actioned. Copies of an advance care plan were found in two residents' files and the staff were aware of these. Staff were

		observed to provide explanations and 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 the Code, which has information on the Advocacy Service. Posters and further pamphlets were displayed and available in the foyer. Family members and residents spoken to were aware of the services provided as they had recently attended a session held for them. In discussion with staff they explained that they were aware of the Advocacy Service and that the residents had the right to a support person. The Advocacy Service has spoken at a meeting for residents and family.
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	All residents interviewed confirmed that they were free to have visitors at any time without restriction and family confirmed that they were always made to feel welcome. External links with the community are encouraged and enabled to continue. Family are welcome to take residents on outings. Activity plans show arranged outings and residents are transported to hospital appointments.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The compliments and complaints policy, which also details the role of advocates, and associated forms meet the requirements of Right 10 of the Code. It described the process for formalising verbal complaints, which according to the complaints register, are being followed through. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. A residents' meeting in 2017 had revealed few knew how to lodge a complaint and the management team arranged for advocacy services to specifically visit the facility to inform residents of the process. The complaints register reviewed showed that eight complaints have been received over 2017 (one had been carried over from 2016; three were staff about other staff) and there were two for 2018 thus far). Details about the complaint(s), and actions taken through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. Depending on the nature of the complaint, the facility manager and/or the clinical nurse manager are responsible for complaint management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A complaint that was being investigated by the Health and Disability Commissioner (HDC) at the time of the last audit was closed out following a two-year investigation process. Correspondence about a separate

		complaint lodged with the Commissioner in July 2017 was sighted. The HDC did not see a reason to follow it through and the issue was addressed by the service provider. There have been no other complaints received from external sources.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed stated that they had been provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service), when they were admitted to the facility. There were posters on display in the foyer and additional pamphlets available along with information on how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Care plan documents sighted included preserving independence, values, beliefs and cultural, social and/or ethnic needs of residents. Staff were observed knocking on doors before entering and treating residents with dignity. Relatives interviewed expressed that staff were professional and care was of a high standard. Records reviewed confirmed that information was gathered on cultural, religious and social needs, values and beliefs during the admission process and then incorporated into the care plan. Staff understood the policy on abuse and neglect and had received training during orientation and annually. Both residents and relatives interviewed had never been subject to, or witnessed, any signs of abuse or neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	At the time of the audit there were no residents or staff who identified as Māori. Staff were representative of many cultures. Recently an International day was held and national costumes worn. International staff expressed they felt part of the team and that their beliefs and values were respected. There is a current, approved Māori Health Plan developed with support from cultural advisors. Staff practise the 'Te Whare Tapa Wha' model of health care combining the spiritual, mental, physical and extended family/whānau in assessment, care planning, and evaluations. Interpreters would be used if required. Links are available to Māori health care providers and there is a glossary of relevant Māori words.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	Residents confirmed that they were consulted on their individual culture, values and beliefs and that staff respected these. Information gathered for each individual was incorporated in the resident's care plan and became part of their daily care. Care plans reviewed showed evaluations that confirmed this was occurring. Residents interviewed verified that their needs were met according to their preferences.

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that they had not witnessed any discrimination, coercion, harassment, sexual, financial, or other exploitation. They expressed that they felt safe living at Annaliese Haven. Relatives commented that staff were professional in their manner.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Best practice is encouraged and promoted by the service through information gathered from such links as Health pathways, Healthlearn, or consultations with Nurse Maude palliative services, wound care specialist, and a continence advisor. Referrals were sighted to domiciliary dentists. The general practitioner (GP) confirmed that referrals were made in a timely manner and that medical intervention was requested and directions followed promptly. The education plan includes the compulsory topics as well as topics of interest that staff have requested. Staff report they receive support from management for external education.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Open disclosure is practiced and was observed in adverse event forms and recorded on family contact records. The family are also given the choice of how frequently they wish to be contacted such as, for major falls or injury, day or night, three monthly or six monthly. Residents and family verified that they were notified about changes to their relative's status and outcomes of medical reviews. These contacts with relatives are documented in residents' files confirming actions taken. Contact information was available for interpreter services. The multicultural staff are also available for interpretation.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	A mission statement refers to the delivery of the best care in a loving relationship by trained and empathetic staff. The motto is about enjoying each day to its full potential and the basics of the vision is about being the best they can be. The strategic plan 2016-2018 describes the business and its scope, the mission, objectives and values of

appropriate to the needs of consumers.		the service and includes a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) analysis. The objectives of this plan are reviewed annually and associated operational plans are in place. A copy of the framework used for reports provided by the facility manager to the owners showed adequate information to monitor performance is reported including financial performance, emerging risks and issues of concern. The service is managed by a facility manager who holds relevant qualifications and has been in the role for two and a half years. Responsibilities and accountabilities are defined in a job description and individual employment agreement, which were sighted. The facility manager has a strong management background in a range of settings including banking, retail, optometry a large charity and the retirement village sector. Knowledge of the residential aged care sector, regulatory and reporting requirements have been developed over time through attendance at residential aged care management update days. A clinical nurse manager supports the facility manager in her role. The service holds contracts with the local District Health Board under the Aged Related Residential Care Service Agreement (ARRC) including for dementia care. Twenty six residents were receiving rest home services and 30 residents receiving dementia care under the ARRC at the time of audit. There have not been any additional risks identified as a result of the change of use for one wing from dementia to rest home services, which occurred at the time of the reconfiguration of services in September 2017 and at the time of significant post-earthquake renovations.
Standard 1.2.2: Service Management 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.	FA	The clinical nurse manager/registered nurse relieves during any absence of the facility manager and carries out all the required duties under delegated authority. According to the staff and the facility manager, this arrangement is working well and the facility manager advised that it is on the agenda for the clinical nurse manager to undertake some formal management training. The clinical nurse manager currently oversees the clinical team on a day to day basis, is an adult educator, has a post graduate diploma and is working towards becoming a nurse practitioner for the older adult. In the clinical nurse manager's absence, other registered nurses in the facility who are experienced in the sector take responsibility for any clinical issues that may arise. Confirmation of the knowledge and skills of the experienced clinical staff were expressed during interview with the GP.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that	FA	The organisation has a planned quality assurance and risk management system that reflects the principles of continuous quality improvement. This lists related legislation, describes a quality framework, includes quality objectives, outlines the quality strategy and covers corrective actions, internal audits, a continuous improvement plan and responsibilities for quality improvement. A quality team includes key managers and representative staff from throughout the organisation. This group meets every two months and there are separate staff meetings. Staff interviewed stated they not only

reflects continuous quality improvement principles.		receive quality meeting minutes that they are expected to read, but are also updated about quality and risk issues at the staff meetings, which was evident in their meeting minutes. Some are involved in internal audits. Meeting minutes demonstrate the issues raised, discussed, reviewed and actioned and include, for example, occupancy, the management of incidents and complaints, internal audit activities, annual satisfaction surveys (resident and family), monitoring of outcomes, infections, any restraint or enable use, corrective action follow-up, the hazard register, and health and safety, which covers risk reviews. Data from the range of quality and risk management strategies is being extracted and used for quality improvement opportunities. Corrective actions are raised when indicated and evidence of these being followed through was sighted. Issues, such as infection rates and adverse events, for example, are benchmarked nationally with other similar organisations. Results of the last resident and family satisfaction survey were viewed, as were those from a food service questionnaire. The surveys confirmed that improvements have been occurring within this facility and people expressed full satisfaction with the services. Issues around food services have been addressed. Monthly residents' meetings include feedback on activities and are an opportunity for the facilitators to access new ideas. Policies and procedures are provided by a quality consultant. Those reviewed during stage one of the audit 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. The document control system that is coordinated by the quality consultant ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The facility manager and the clinical nurse manager described the various processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The clinical nurse manager is familiar with the Health and Safety at Work Act (2015) and is the health and safety officer. With support from the facility manager, she has implemented the requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and	FA	The facility manager and the clinical nurse manager were familiar with the range of statutory and/or regulatory obligations in relation to essential notification reporting. Examples were given and described. The managers reported that there has not been any need to notify significant events since the previous audit, although the service has been involved in two mediations for employment disputes, which were discussed and reportedly had satisfactory outcomes. The adverse event policy and procedure is comprehensive which includes a description of the investigation process. Incident forms are being completed by relevant staff when applicable, actions are taken, open

where appropriate their family/whānau of choice in an open manner.		disclosure with family members and the person (as appropriate) is occurring and the information about each is collated. Adverse events are collated according to predetermined categories, possible contributing factors are identified, and preventive or corrective measures implemented to mitigate the risk of recurrence. The analysis process includes graphs and the conclusions are conveyed to staff at quality meetings as well as at all staff meetings. Where necessary, the issue is transferred onto the hazard register or the risk register. Staff confirmed they are kept informed of incident reports and of any corrective measures implemented.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. Recruitment processes include formal application and interview processes, referee checks, police vetting and validation of qualifications and practising certificates (APCs) as required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Annual practising certificates for all registered health professionals associated with the service including the pharmacists, dietitian and GPs have been checked and records kept. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepares them well for their role and noted that the programme is varied according to individual requirements. Staff records reviewed show documentation of completed orientation, a performance review after a three-month period and annually thereafter. Continuing education is planned on an annual basis and the 2017 and 2018 schedules include mandatory training requirements. Separate registered nurse training schedules are developed and include key professional development opportunities as well as special interest topics and access to a 10 module palliative care course. All training schedules are comprehensive and demonstrate a variety of organisations contribute to staff training at Annaliese Haven. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The clinical nurse manager is the internal assessor for the programme. Training attendance is paid and well promoted with text alerts and reminders, colourful flyers and reminders at performance appraisals. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments.
Standard 1.2.8: Service Provider Availability	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery over 24 hours a day on seven days a week. This covers annual leave, rostering,

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		staffing rationale, staff replacement, special events and roster changes. The facility manager and the clinical nurse manager work eight hours a day Monday to Friday. A registered nurse is routinely on duty in this facility for all shifts, except for night shifts, and one is allocated for after hours on-call. One is always available in the dementia service areas on morning and afternoon shifts with a skilled senior caregiver covering the rest home. The on-call registered nurse has access to the facility manager for non-clinical issues as well as the clinical nurse manager for clinical issues. Staff confirmed that they have good access to additional support at all times. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. In the first instance, staff are invited by a text message to undertake an additional shift; otherwise a bureau staff person is brought in. This is reported by managers and staff as only being needed on rare occasions. The current and three previous weeks of rosters sighted show that at least one staff member on duty has a current first aid certificate and there is 24 hour seven days a week registered nurse coverage in the rest home with one on duty 6.45am to 11pm and one on call 11pm to 7am. The facility adjusts staffing levels to meet the changing needs of residents and examples of such situations were discussed. Rules around the number of shifts staff work in a fortnight and the number of hours off duty between shifts are being upheld. A new system of staff allocation has been implemented that ensures all staff, including night shift are aware of residents' needs over all shifts. Teams have been developed and they rotate shifts and work areas every five to six weeks. This has reportedly improved resident and staff relationships in a positive way.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service provider's confidentiality and privacy policy clearly described expectations and references relevant to legislation. 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. Archived records are held securely on site and are readily retrievable using a cataloguing system. Older records are taken offsite to the Elsdon Enterprise Limited office. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. During interviews, staff were aware of the need to maintain confidentiality about residents and their associated information.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Services Coordination (NASC) service. The clinical nurse manager has developed a resident enquiry sheet that has been in use for a year. This tracks enquiries and the rate of admissions that follow. 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 pack of information for prospective and new residents is comprehensive. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. One resident talked about the personal difficulties when admitted but had no criticism of the admission process. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. When respite care is provided, and updated information is sought from family, the GP and the NASC as appropriate and prior to each admission.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner according to policy documentation. The maintenance person transports the residents to appointments when family members are unable to do so and a senior staff person will always accompany if the person is from the dementia service. Rest home residents may choose to go alone. 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. Staff informed that registered nurses provide verbal handovers when applicable, in addition to the paperwork. All referrals are documented in the progress notes. The file of a resident who had recently been to hospital was reviewed and included evidence of open communication with family of the resident being kept well informed during the transfer of their relative. A family member stated that they were well informed about all aspects of care and support provided.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff demonstrated good knowledge and had a clear understanding of their roles and responsibilities

that complies with current legislative requirements and safe practice guidelines.		related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied in pre-packaged form 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 on request. 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. The temperature records for the medicine fridge were within the recommended range. Good prescribing practices were evident and included commencement and discontinuation of medicines. All requirements for pro re nata (PRN) medications were being met. The required three monthly GP review is consistently recorded on the medicine chart. There was one person who self-administered medications at the time of audit. Appropriate processes are in place to ensure that this is managed in a safe manner. Twenty four medication records were reviewed. There is an implemented process for comprehensive analysis of any medication areas.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by two cooks and four kitchen hands. All have completed their food safety certificates which were sighted. The menu is a four week rotating cycle with up to three changes over the year. The menu was reviewed in April 2018, by a qualified dietitian and is in line with recognised nutritional guidelines for the elderly. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures are within acceptable range. Fridges and freezers are maintained at recommended level with temperature records sighted. A nutritional assessment is undertaken on admission and dietary profile formulated and forwarded to kitchen. Note is made of special cutlery, lipped plates, likes and dislikes, allergies, or special diets and modified texture requirements are displayed in the kitchen and accommodated in the daily meal plan. Residents in the dementia unit have snacks available to meet their food and fluids requirements. Residents and family interviewed expressed that they enjoyed the meals which includes a variety of food. Residents observed at mealtime were given sufficient time to eat their meals in an unhurried manner.
Standard 1.3.2: Declining	FA	The managers advised that the local needs assessment services are aware of the services provided at

Referral/Entry To Services 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.		Annaliese Haven and referrals are generally appropriate. However, in instances where at the enquiry level it has been felt that not all the needs of the person could be fully met, entry has been declined and the enquirer redirected. Suggestions of other facilities have been made including linking people back to the needs assessment service. There is not currently a waiting list at this facility. If the needs of a resident change and the person is no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Initial assessments are undertaken over the first three days and registered nurses oversee the completion of monitoring forms for issues such as sleeping and continence during this timeframe. Information is documented using validated nursing assessment tools such as pain scale, nutritional needs, including development of a dietary profile, skin integrity and pressure area prevention and any behaviours of concern. Results of these assessments contribute to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information from the resident (when appropriate), family members, the GP and other medical and allied services the person was associated with. All residents have current interRAI assessments completed within the first three weeks at the facility, by one of the trained interRAI assessors on site. Rest home residents and family members confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Family members contribute to the care planning process at the level they choose, especially for residents in the dementia service, and residents are involved at the level they are able to contribute. Both short and long-term care plans were sighted. Although a template is used, all are individualised according to each person's needs and preferences with details of required interventions. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff, usually at shift handovers. There was evidence of open communication processes between disciplines.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents is consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is overseen by experienced registered nurses. Note was made of the significant improvements since there had been additional input from registered nurses. Care staff confirmed during interviews that care was provided as outlined in the documentation and that they are well supported by the registered nurses and the clinical nurse manager if they have any questions. There is also a strong team of senior caregivers who demonstrated familiarity with the residents and communication and interventions observed by all staff was meeting residents' needs. A range of equipment and resources is available, suited to the level of care being provided and was in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	CI	A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The monthly schedule shows a diverse range of activities that include innovation and creativity. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys, personal six monthly evaluations and informal conversations. Residents in both the rest home and from the dementia service who were interviewed confirmed they find the programme varied and ever changing with always something to do or somewhere to go. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities that include folding linen, staff reading to residents, garden walks and music listening, for example, are offered at times when residents are most physically active and/or restless. All residents in the dementia service whose files were reviewed have a 24 hour activity plan in place. The resident driven activity programme is operating as a continuous improvement project with ongoing developments and reviews occurring. Planned activities have moved from an almost non-existent level to one that is credible in such services.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Other key assessment tools, such as for pain and skin integrity, are also reviewed and compared with previous outcomes. The reassessment and review process includes those aspects of the care plan that are activity related. Where progress is different from expected, the service responds by initiating changes to the plan of care. Multiple examples of ongoing monitoring were sighted with examples being for nutritional intake, behaviour manifestations (in particular in the dementia service) and mobility. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds, skin tears and weight loss. 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 and family members stated that informal discussion is ongoing.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are assisted to access or seek referral to other health and/or disability service providers. Examples of such access include various clinics and services at Nurse Maude, health pathways for dental services, the community physiotherapist, palliative care clinical nurse specialist, the older persons' health needs assessment and coordination services. Although the service has a 'house doctor', residents may choose to use another local medical practitioner/GP. If the need for other non-urgent services are indicated or requested, the GP or registered nurse sends a referral to seek specialist input. Copies of referrals and follow-up communication from medical specialist and various allied health services were sighted in residents' files. The resident and the family/whānau are kept informed of the referral process, as verified by documentation in communication recording sheets in residents' records and during family interviews. An example of an explanation provided to a resident prior to an appointment was heard during the audit. Evidence of changes to the long term care plan, and one of development of a short term care plan, were sighted regarding wound management and a dietitian visit follow-up. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance. The GP advised that this is usual practice out of hours as there are no local 24-hour clinics.
Standard 1.4.1: Management Of Waste And Hazardous	FA	Staff follow documented processes for the management of waste and infectious and hazardous material. Appropriate signage is displayed where required. Chemical training has been completed and attendance records sighted. Material safety data sheets were displayed and staff interviewed were able to explain the

Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		process for chemical spills. An external provider collects the rubbish skip twice weekly which is stored around the side of facility screened off from view. Personal protective equipment (PPE), including face shields, gowns, and gloves are available around the facility and staff were observed to be using it appropriately.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current Warrant of Fitness which is publicly displayed in the front entrance. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documents reviewed, on interview with the maintenance person and observation of the environment. There is a maintenance book where staff can document anything requiring attention. It was observed that actions were signed off promptly. The maintenance employee is responsible for checking water and room temperatures. On observation of the records they were within required recommendations. Records show that required checks of fire equipment are being upheld by a contractor. Renovations in a wing that was previously used for dementia care residents have been completed and have addressed earthquake damage. There has been no change to any aspect of the fire safety systems. The rest home residents in this wing have good access to a sitting area, the lounge and dining areas and to external courtyards. There is a large paved area outside where residents have the freedom to wander and participate in meaningful exercise. The gates at either end of the area are protected by key pad locks. There are comfortable chairs for sitting outside as well as a sheltered area for resident smokers. Residents spoken to were positive about the outside area.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving	FA	Staff interviewed stated that there were sufficient toilets and bathrooms. Half the rooms have an ensuite included in the rest home area. Appropriate secured and approved hand rails are provided in toilet/shower areas, and other equipment/accessories are available to promote residents' independence.

assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The rooms are a good size and allow safe movement for the residents. All bedrooms provide single accommodation. Residents' bedrooms are personalised with furnishings, photos and personal items. Residents and staff reported that there was room to store mobility aids and wheelchairs. Mobility scooters are stored outside under waterproof covers.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. Both lounges and dining rooms are spacious and enable easy access for residents and staff. Places are available for residents to sit with relatives in private if desired. Furniture is appropriate to the setting and the residents' needs. Staff and relatives interviewed expressed that they liked the large, uncluttered environment.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site in a dedicated laundry. Laundry staff understand the laundry process, having completed chemical training and a New Zealand Certificate in Cleaning Level 2 Healthcare Strand. There is a flow from dirty to clean. Personal protective equipment is available and observed to be worn. Designated colour linen bags are assigned, and lids kept closed. Chemicals were stored appropriately in a locked room. Internal audits occur to monitor the laundry service. Residents and family interviewed said that clean laundry was returned promptly, and residents were given the choice of putting it away in their drawers themselves. Cleaning of the facility in a safe manner with appropriate signage used indicating, for example, wet floor. Chemical training and a New Zealand Certificate in Cleaning Level 2 Healthcare Strand have been completed by all housekeeping staff except for a cleaner who has only recently started. Certificates were sighted. Training occurs annually.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	Staff reported they undertake emergency training at orientation and then yearly. This was confirmed in staff training records. There is an approved evacuation plan. Fire drills occur six monthly, the last being in April 2018. Checks on the fire equipment and fire system are consistently undertaken. Staff interviewed indicated that they understand the evacuation and emergency procedures, and were aware of where the

Consumers receive an appropriate and timely response during emergency and security situations.		civil defence kit is stored and the procedure if discovering a fire. A civil defence kit is stored in the nurses' station with further supplies of gowns, gloves and incontinence products stored in a designated room. Bottled water was also available and a gas barbecue as alternative cooking supply. Call bells are in place and were observed to be answered in a timely manner. Residents reported that call bells are answered promptly. Residents expressed that they felt that Annaliese Haven was a safe place to live. External doors are locked at the time of the evening meal and curtains pulled at dusk. Visitors are requested to notify staff when leaving the facility after doors are locked.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Residents and staff said that the building was kept at a consistent temperature. All bedrooms have windows that utilise natural light. Security latches are in place but allow windows to be opened. Water and room temperatures are checked by the maintenance man and recorded monthly. All temperatures were within recommended range. There is a sheltered smoking area outside with adequate seating for those who choose to smoke. A separate area is available for staff.
Standard 3.1: Infection control management 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.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, visitors and staff. The IPC programme is reviewed annually. The clinical nurse manager holds the position of IPC coordinator. Infection control data including surveillance results are reported monthly to the facility manager and quarterly to the board. Results and recommendations are reported back to staff at staff meetings, as well as being displayed in the staffroom. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the last 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell and staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human,	FA	The IPC has appropriate skills, knowledge and qualifications for the role, attending external study days. Support is available from CDHB, community laboratory, the GP and public health nurse as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		There is a well-developed plan for dealing with an outbreak. There have been no out breaks since the surveillance audit in 2017. Staff training includes hand hygiene, use of PPE, and outbreak management. Staff interviewed felt confident in their knowledge of infection prevention and control. Internal audits of the infection control programme showed a sound understanding.
Standard 3.3: Policies and procedures 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.	FA	Documented policies and procedures for the prevention and control of infection reflect current accepted good practice. These policies and procedures are practical, safe and suitable for the type of service provided. Care staff, laundry and kitchen staff were observed following organisational policies, such as wearing gloves, and disposable hats in the kitchen. Hand sanitisers are readily available around the facility and all staff were observed using them. Staff interviewed verified that they understand the infection and control policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education at orientation and ongoing sessions. Education is provided by suitably qualified registered nurses and the IPC coordinator. Staff indicated that if there is a higher than usual number of particular infections, that toolbox talks are implemented at handover to give reminders. Records of attendance are kept. Some e-learning courses have also been utilised. Flu vaccines are available to both residents and staff. Staff encourage residents with cough etiquette.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	Surveillance is appropriate to that recommended for long term care facilities. Infections monitored include eye, skin, influenza, urinary tract, upper and lower respiratory tract infections. The IPC coordinator reviews all reported infections, and these are documented. Staff are aware of reporting any sign of infection, for instance fever or change of behaviour, to the RN so

specified in the infection control programme.		prompt treatment can begin. Monthly surveillance data is collated and analysed to identify trends, possible causative effects, and required actions. Graphs are produced which are displayed in the staffroom and used to compare trends with other years and within the same year. Results of surveillance data are shared with staff at bimonthly staff meetings. It is also presented at the quality meetings with the facility manager, and quarterly with the board.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are currently no restraints in use at Annaliese Haven. The clinical nurse manager is the restraint coordinator. There are policies and procedures to follow if restraint is required including assessment, consent, type of restraint, monitoring and evaluation. Approved restraints and the instruction to use the least restrictive restraint for the shortest time and only when all other avenues are exhausted was confirmed by staff interviewed. Staff receive training on restraint usage during orientation and then receive updates every two years. Restraint usage is reported to the quality meeting as observed in meeting minutes. Restraint (personal) was last use in the facility in March 2018 for a period of one minute for a person who had an acute infection. This was to reduce the risk of physical harm to a staff member and was ceased as soon as it was no longer required. The main use of enablers in recent years has been bed loops to help residents maintain independence, none are currently in use.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	CI	Overall, registered nurses are responsible for all stages of service delivery. It had been identified that caregivers required additional support, therefore a concerted effort to increase the number of registered nurses was made. Once registered nurses had been employed, it was observed that some needed considerable upskilling to ensure they had the skills to undertake their roles. The clinical nurse manager put together an education programme, specific to Annaliese Haven to upskill the registered nurses. This has been evaluated, not only at each topic level, but considering the benefit for both the registered nurse and the facility. All results are positive and an observation has since been made that when two of these people resigned, considerable gaps were left in the service. The programme was reinstated for the replacement registered nurses. The GP confirmed during interview that additional registered nurses have made a considerable positive difference in the services delivered, especially since those with less experience, or who were new to New Zealand, have been upskilled. Another initiative in place since April 2017, commenced when concerns were	Systems put into place to improve service delivery have seen an increase in the number of registered nurses employed to support caregivers. Also, a programme has been implemented to upskill and improve the competence of less experienced registered nurses. Evaluations have confirmed that all aspects of service delivery have since improved. In addition, systems have been implemented to improve the follow up of adverse events occurring out of hours. This has resulted in improved competence of involved staff, including caregivers, and more efficient and effective

		identified that insufficient information was being passed on following out of hours calls to registered nurses and care staff were struggling to convey the correct information about what had happened. An on call form is now utilised (examples sighted) for each out of hours call to a registered nurse. A morning shift registered nurse follows the issue up to ensure appropriate follow-up and observations have occurred and completes the form. The clinical nurse manager follows this up further. Evaluations of this system are stating that there is earlier identification of serious issues, it has reduced the strain on registered nurses going into the facility during the night, night calls have since decreased, care staff have improved guidelines for adverse events and residents are ultimately managed more efficiently and more effectively.	management of services delivered.
Criterion 1.3.3.3 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.	CI	Following earlier non-compliances regarding interRAI assessments and reassessments not being undertaken in a timely manner, the clinical nurse manager developed a system to ensure the registered nurses would be more accountable for these. The system has since developed beyond interRAI and is demonstrating continuous improvement by ensuring each stage of service provision is completed in a timely manner. Every Monday, registered nurses are required to submit a form that has a checklist of their allocated residents. The checklist requires them to confirm that short term care plans have been reviewed, that all residents' notes have been reviewed weekly and written into by the registered nurse, to verify that monthly observations are up to date, that any interRAI, development of a long term care plan or resident review that is due has been completed or is underway. The intention is to ensure that all residents have been fully reviewed by a registered nurse for that week, to ensure registered nurses are accountable for their responsibilities and as a guarantee to the clinical nurse manager that the health and disability services standards and the contractual requirements around service delivery are being met. An evaluation of the use of this form has been documented. Another system implemented is that a multidisciplinary/care plan review schedule describes requirements around interRAI and reviews of care plans, including the social/cultural and spiritual section of the care plan. Registered nurses undertake this in consultation with senior caregivers, family and the residents (as applicable). A sheet records which registered nurse is responsible for each resident and who is due on which month. This is	Three separate systems have been implemented that are ensuring improved accountability of registered nurses around meeting contractual timeframes for each stage of service delivery. Evaluations also inform that overall service delivery requirements have improved, registered nurses are managing their time more effectively and workloads are being distributed better.

		accompanied by a spreadsheet of the residents' names, which details key events such as admission dates, dates of each interRAI assessment, dates of long term care plans and who the primary nurse is. The primary nurse is identifiable by colour coding. In addition, the 'TO DO' dashboard on momentum is printed weekly and used to guide registered nurses to be aware of the timeframes and aligns with the spreadsheet, which uses the same primary nurse colour coding. This is supported by a care plan/multi-disciplinary team distribution plan which provides registered nurses with clear information about who is due for six monthly assessments, care plan reviews their multi-disciplinary review and evaluations. These systems have been in place for two years and the evaluations inform that there is now a flowing system that is ensuring continuous and updated service delivery for all residents and that contractual timeframe requirements are being met. It is claimed that registered nurses now manage their time more effectively and workloads are better able to be monitored.	
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	CI	The initiative described in 1.3.3.1 regarding the management of out of hours calls has contributed to staff working more co-operatively, especially caregivers and registered nurses and contributes to the continuous improvement for this criterion. In addition, as a result of an unwitnessed incident and as a result of a concern that staff could not always locate residents easily, a resident safety check sheet was introduced to improve awareness of all dementia residents on a half hourly basis. Staff work as a team to ensure they know the whereabouts of all dementia residents at specific times. The evaluation notes it is an invaluable tool that is now also being used in the rest home for higher risk residents. The system is enabling half hourly monitoring of residents and early evaluations are suggesting that falls are reducing and inappropriate altercations between residents are not occurring as often due to the closer monitoring. Part of the evaluation suggests that staff (including auxiliary staff) work together more to meet this requirement and that communication between staff, including between different roles have improved. Continuous improvement is being demonstrated from these two initiatives, albeit this was not the initial objective of them.	The above described initiative in regard to managing out of hours call has contributed to caregivers and registered nurses working in a coordinated manner that is improving service delivery. Likewise, the implementation of the use of a resident safety check list has resulted in staff increasingly working as a team whilst improving residents' monitoring and safety.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	A continuous improvement rating has been allocated to this criterion/standard due to the significant input that has gone into ensuring residents are increasingly engaging in activities in a meaningful way. Marked changes have been implemented in response to corrective actions raised in relation to the activity programme in both external and internal audits. At that time there were no trained diversional therapists, the programme lacked variety and energy, there was a lack of resources, unnecessary behavioural traits were evident with some residents and complaints made that people were not well occupied. The managers implemented a plan, which has involved the employment of suitable staff, one of whom is a trained diversional therapist who holds a national Certificate in Diversional Therapy and another is a person currently undertaking her training as a diversional therapist. Both work between the rest home and dementia services, which enable them to be flexible. There are strong links between the clinical nurse manager and the diversional therapy team, who with the facility manager have built credibility into the activity programme. Caregivers are encouraged and supported to be involved in residents' activities. In addition to new staff, additional resources and a dedicated activity budget have been instituted. The staff attend ongoing professional development and are part of the North Canterbury Support Group of Diversional Therapists where skills and knowledge are shared. Links with community organisations and resources have become strong and cover social, spiritual, physical and recreational examples. Innovative activity ideas are being implemented. For example, a pet therapist now visits twice weekly and residents visit her mini farm regularly. The evaluations are showing residents are calmer and more settled with one person now socialising and becoming more sociable since the visits. A separate initiative was that a large hardware company asked if they could work with the facility to improve the quality of life for residents at Annaliese Haven. This saw a community project developed with a team from the store going to build a Man's shed and raised gardens. Rest home residents said they felt a sense of purpose and saw the benefits of their work, while those from the dementia unit showed happiness and contentment. This was considered successful and stage two is being planned. Of note is the level at which the activity programme is resident driven, including for those in the dementia service. Monthly resident meetings contribute to this process. Attendance numbers at all activities, such as 'happy	Internal and external corrective actions prompted the service provider to allocate funding and resources to a meaningful activity programme. Suitably qualified dynamic staff have been employed and are being supported to implement a resident driven diverse activity programme that includes community links and opportunities of a holistic nature. Innovative projects, including a community based project, have been implemented into the activity programme. Evaluations of the activity programme are occurring at all levels, including individual, resident groups, staff, quality meeting and reports to governance.

		hour' and exercises, for example, has greatly increased and is being used as a marker of success and for further ideas and development. There was a high level of respect and responsiveness demonstrated for residents' preferences and their individual responses to opportunities with an example being resident preferences to go to places with a destination such as shopping, or to see something unique. Overall, there was evidence that not only has the service responded to the need for appropriately skilled staff and an activity plan suitable for the service, but this has been done at a commendable level. Reviews and evaluation are occurring at the individual level and was evident in care plan reviews, at the group level with feedback to residents' meetings, at the organisational level with feedback from wider staff, and at the quality meeting level as noted in meeting minutes and in activity programme reports to the governance unit.	

End of the report.