

Orewa Beach View Retirement Home & Hospital Limited - Solemar

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:	Orewa Beach View Retirement Home & Hospital Limited
Premises audited:	Solemar
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 26 April 2018 End date: 27 April 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:	25

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Orewa Beachview Retirement Home and Hospital Limited provides rest home, hospital and secure dementia care services for up to 29 residents. The service is operated by Solemar and managed by an owner/director, facility manager and clinical manager. Residents and their families/whanau 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 members, management, staff and a general practitioner.

The audit has resulted in 10 areas requiring improvement related to informed consent, adverse events management, entry to service, general practitioner reviews, initial assessments and initial care planning, referral to other health professionals, short term care planning, medication competencies, foodservice, restraint minimisation and safe practice and infection prevention and control.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination. Family members are encouraged to visit.

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

A complaints register is maintained with complaints resolved promptly and effectively. One external complaint is yet to be documented and resolved.

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.		Some standards applicable to this service partially attained and of low risk.
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The organisation's business, quality and risk plan includes the scope, direction, goals, values and mission statement of the organisation. Monitoring of services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families as verified in interviews. Adverse events are documented with corrective actions implemented. Actual and potential risks including health and safety risks are identified. Policies and procedures support service delivery, were current and are being implemented.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes annual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is recorded, securely stored and not accessible to unauthorised people. Information was held in the residents' integrated 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Prospective residents and family members are provided with information on the facility and services prior to and on entering the service.

The multidisciplinary team, including registered nurses and a general practitioner, are involved in assessing residents' needs. A podiatrist and physiotherapist are involved where required. Care plans are individualised, based on a range of information and assessments. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

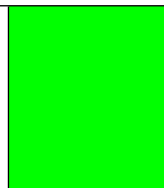
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely stored and managed and reviewed by the general practitioner at least every three months.

Special dietary needs are catered for. Food is safely managed. Most residents or family members reported 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.

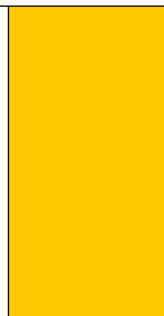
The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide seating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

Waste and hazardous substances are well managed. Staff use personal protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Personal laundry is undertaken onsite and other laundry is collected and delivered by an external contractor. Products are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are practised six monthly. Residents reported timely staff response to call bells. Security is maintained at all times 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.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The organisation has implemented policies and procedures that support the minimisation of restraint. Three restraints were in use at the time of audit. Approval and monitoring processes with regular reviews occur. Use of enablers is voluntary for the safety of residents. No enablers were in use at the time of this audit. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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Infection prevention and control activities are facilitated by the clinical manager. Specialist infection prevention and control advice can be sought as needed. Residents are offered influenza vaccinations.

Staff demonstrated good principles and practice around infection prevention and control which is guided by relevant policies and procedures and supported with education.

Surveillance is undertaken, data is analysed and trended and results are reported back to staff. Follow-up action is taken as required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	4	5	1	0
Criteria	0	91	0	4	5	1	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	The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
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.	PA Moderate	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent forms and includes storage of information, medical treatment, transportation and obtaining a resident photograph for identification. Competent residents or family members with enduring power of attorney (EPOA) have signed the consent forms. Records detail if the EPOA has been activated. Consent for influenza vaccination was also present in files, or on occasion, verbal consent was noted to have been obtained via phone from the EPOA where circumstances required. One patient had a separate consent form for the use of subcutaneous fluids. On occasions, the resident's or family members declining of treatment or referral offers was also noted. Staff were observed to gain consent for day to day care. Residents and family interviewed reported they were

		<p>happy with the support that staff provided, for example, day to day conversations and different options provided.</p> <p>Not for resuscitation decision forms are present in the patients' notes. These have been signed by the enduring power of attorney for residents who are not competent in decision making. This is an area requiring improvement.</p>
<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 information on the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager was able to provide examples of where they would encourage the involvement of Advocacy Services. Examples were sighted in residents' files of family members advocating on behalf of the resident.</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 a variety of organised outings, visits, activities, and entertainment. Family and friends were observed coming to collect residents for social outings during audit.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited regardless of the time and were comfortable in their discussions with staff. Where applicable (eg, providing end of life care), family members can stay overnight to provide their family member with love and support.</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/compliments policy and associated forms meet the requirements of Right10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints/compliments register showed that there were four verbal complaints and three written complaints since the previous audit and that action was taken through to an agreed solution and documentation was completed within the required timeframes. Action plans showed any required follow-up and improvements have been made where possible. Each complaint was signed off by the facility manager and dated. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>At the commencement of the audit the facility manager was asked if there had been and complaints</p>

		received from any external sources since the previous audit and the facility manager stated there had been none. There was one Health and Disability Commissioner letter sighted 06 April 2018 at the end of the audit which had not been disclosed at the opening meeting and was not documented on the organisation's complaints register. While Orewa Beachview Retirement Home and Hospital Limited was not the subject of the complaint at this time it was noted that the complainant is a resident and receives rest home care at this facility. The facility manager has yet to respond to the request for information.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and / or family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, and discussion with management. The Code is displayed in both reception / entrance areas together with information on advocacy services. Staff advise the Code is available in other languages on the Health and Disability Commissioner website and will be accessed if applicable.
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	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a single occupancy room. Security cameras monitor communal areas only.</p> <p>Residents are encouraged to maintain their independence by attending community activities (where able), and participation in activities of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that the admission nursing assessment includes an area to identify resident's individual cultural, religious and social needs, values and beliefs. While this had not been completed for some new admissions (refer to 1.3.3.3.), residents and family members interviewed confirmed their needs had been met. Where individual needs had been identified, these had been documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur at orientation and training was last held in January 2018.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	Staff advised they provide support to residents in the service who identify as Māori to integrate their cultural values and beliefs. There are currently no residents who identify their ethnicity as Maori in the facility. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the

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.		importance of family involvement in care / support. There is a current Māori health plan that acknowledging the four cornerstones of Maori Health, which include Whanau (family health), Tinana (physical health), Hinengaro (mental health) and Wairua (spiritual health). The activities programme includes cultural activities, such as celebrating the Treaty of Waitangi as a special day, poi making and other cultural activities.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	Residents and family members interviewed identified that their individual culture, values and beliefs are respected by staff. Resident's personal preferences, required interventions, and any special needs identified had been included in care plans reviewed. In the event a resident did not want to participate in specific activities, this was also noted in either the care plan or activities plan. The resident satisfaction survey in October 2017, and interviews with residents and family members confirmed that individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed stated that they had no concerns about any staff conduct or behaviour for themselves, their relative, or for how staff interacted with other residents. Staff have completed training on the code of conduct. The expected behaviour of staff is also detailed in staff employment agreements. Staff interviewed could detail the behaviour expected of them. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of discrimination or coercion occurring.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, and wound care specialist. The facility is participating in a pilot education programme with the hospice (this started in November 2017), aimed at improving outcomes of patients receiving palliative care. The clinical nurse manager has completed the foundations of palliative care training and has completed two subsequent workshops. The next step is for the clinical manager to work two days with the hospice team in 'submersion' to enhance clinical skills. A hospice nurse was visiting Solemar during the audit and identified a prompt and professional working relationship existed between the hospice staff and the Solemar team.</p> <p>Staff are provided with ongoing education relevant to their roles. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and staff were responsive</p>

		<p>to medical requests.</p> <p>Other examples of good practice observed during the audit included knocking on residents' doors before entering, and day to day conversations between staff and residents and visiting family members. Staff were observed assisting residents with meals in the dining room. The ambient noise was kept to a minimum and residents allowed to eat at their own pace, with or without assistance.</p>
<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>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. As part of the admission process the family are able to identify if they want to be informed of all incidents or those of a more significant nature and specify communication timeframes. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Family members gave examples of the timely communication that occurred between staff and them.</p> <p>There is one resident who does not speak English. Staff knew how to access interpreter services if required. Staff reported this was not often required due to the resident often having family members who are able to communicate in English being available by phone, and who also visit frequently. Simple phrases and key words have been translated from English to the resident's language and this was sighted. Staff also utilised the internet on occasions for interpretation if they were unsure what the resident was saying. Staff also noted body language and facial expressions also helped convey non-verbal messages.</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>The business quality and risk management plan 2018 – 2019 was reviewed. The purpose, values, scopes, direction and goals of the organisation are documented. The document reviewed described longer term goals, provides direction for the organisation, was known to staff (with the exception of finances), and is reviewed annually. There is a quality statement which describes the values and how these will be met. The plan is divided into customer focus, provision of effective programmes, certification and contractual requirements, quality and risk management and controls. Quality improvement (four objectives are set) define the corrective action process which occurs at regular staff meetings.</p> <p>The service is managed by a facility manager who is a registered nurse with aged care experience and has been in this role for six months. The facility manager reports to the two owner directors. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending related business study days.</p> <p>The service has contracts with Waitemata District Health Board (WDHB) for up to 29 residents. At the time</p>

		of audit there are (4) rest home residents, (11) hospital level residents and (10) secure dementia level care residents.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, the clinical manager carries out all the required duties under the delegated authority with support from the owner director. During absences of key clinical staff, the senior registered nurses, who are experienced in the sector, are able to take responsibility for any clinical issues, as is the facility manager who also retains a registered nurse annual practising certificate. Staff reported that the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned business, quality and risk system that reflects the principles of continuous quality improvement and is understood by staff. This includes the management of incidents and complaints (refer to criterion 1.1.13. and 1.2.4), audit activities, a regular resident/family satisfaction survey, monitoring of outcomes, clinical incidents including infection and restraint minimisation and safe practice. A recent resident/family survey has been distributed on the 9 April 2018 with only four replies so far with positive feedback. Family members interviewed provided positive feedback about care and services provided.</p> <p>Terms of reference and meeting minutes confirmed more than adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of key indicators occurs, and related information is reported and discussion at the staff/quality meetings. Minutes of meetings reviewed included discussion on pressure injuries, restraints, falls, complaints, incidents, events, infections, audit results and activities. The owner/director responsible for the business management records and completes quality and risk activities through the internal audit activities, as per the completed audit schedule. The owner director and the facility manager collate all data on all aspects of service delivery. Audit records were reviewed and discussed with the owner/director. Relevant corrective actions are developed and implemented to address any shortfalls and demonstrated a continuous process of quality improvement is occurring.</p> <p>Orewa Beachview Retirement Home and Hospital Limited has newly implemented policies and procedures since the previous audit. A contracted quality consultant has developed all policies and procedures used in this facility. All legislative requirements are effectively met. Previous obsolete documents are stored appropriately. An archive system is utilised and records can be retrieved as needed. All records are dated 1 September 2017.</p>

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 where appropriate their family/whānau of choice in an open manner.	PA Low	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse events data is collated, analysed and reported to staff and to the business owner/director. The forms are kept in a folder by month and as yet have not been filed in the individual resident's records reviewed. There is no evidence of an individual incident/accident log being maintained in the individual resident's records reviewed as per the policy reviewed. Summaries and graphs are developed with type of incident, any injuries sustained, time of incident/accident and time of day to identify any trends.</p> <p>The facility manager described essential notification reporting requirements. The facility manager stated there had been one Section 31 notification for a resident admitted with a grade four pressure injury since the last audit.</p>
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	<p>Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis including mandatory training requirements. Health care assistants have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements with the WDHB. The clinical manager and the facility manager facilitate any education and the owner/director maintains the electronic records reviewed for all staff. All staff who work in the secure dementia service have completed the relevant dementia training. There are three of four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. One current registered nurse has put in a recent resignation and two registered nurses have been recruited (awaiting visa authorisation) who are trained in interRAI. Records reviewed demonstrated completion of the required training and annual performance appraisals.</p>
Standard 1.2.8: Service	FA	There is a documented and implemented process for determining the staffing levels and skill mixes required to provide safe service delivery 24 hours a day, seven days a week (24/7). The policy states that

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>staffing levels reflect the number of residents, residents' care levels and the layout of the facility is taken into consideration. The facility manager adjusts staffing to meet the changing needs of residents. An afterhours on call roster is in place with staff reporting that good access to advice is available when needed. Health care assistants reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of the rosters confirmed adequate staff cover has been provided with staff replaced as necessary for sick leave and annual leave. There is a registered nurse on 24/7 to cover this facility. Two health care assistants are in the secure dementia service at all times. The registered nurses are working 12 hour shifts to ensure the services are covered adequately. Two registered nurses are currently being recruited (both are interRAI trained which will be an asset to the organisation).</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Most necessary demographic, personal, and health information was present 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. Several documents were unable to be located in residents' files (including archived documents) during audit. This is included in the area for improvement raised in 1.3.3.3.</p> <p>Archived records are held securely on site and are readily retrievable. No personal or private resident information was on public display during the audit. The management team are aware of their responsibilities for archiving resident records and for what period.</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>	PA High	<p>Entry to service processes are defined. Residents requiring rest home, private hospital and secure dementia care can be admitted. There are currently three residents in the secure dementia unit that have been assessed as requiring either rest home or private hospital level of care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing</p>

<p>transition, exit, discharge, or transfer from services.</p>		<p>management of the resident. This was observed during audit when a resident required transfer to the DHB hospital following a fall. The family and GP were informed. Copies of key records including medication charts, EPOA documents, and next of kin contact details, and a written transfer record summarising the resident's care needs accompanied the resident.</p> <p>All transfers out are documented in the resident's file. Another resident has been admitted to the DHB twice in 2018. A copy of a transfer letter to the DHB and the subsequent discharge summaries are on file. Records are on file of another occasion where the ambulance was called. The resident was not subsequently transferred, and the rationale and information that informed the decision making is documented in the resident's file.</p> <p>Another resident's file reviewed contained documented communications with family about an unwell resident. The families stated wish was that care be provided at Solemar. The family did not want the resident to be transferred to the DHB hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies required aspects of medicine management in line with legislation and current accepted practice.</p> <p>A system for medicine management (using an electronic system) was observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of her role and responsibilities related to each stage of medicine management.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. A supply of impress medicines is available for use for hospital level residents if required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff (one must be a RN) when administering. Records displayed on the medicine room wall details the names of staff competent to check controlled drugs and insulin, or to administer oral medicines. This record does not correlate with the information in the staff files. (Refer 1.3.12.3) The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of the daily temperatures for the medicine fridge were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. Photographs are attached to the medicine records on all but one of the 20 residents' medicine charts reviewed. The absent photo was for a new admission. The required three-monthly GP review was consistently recorded on the applicable medicine charts. The CM advised standing orders are not used.</p>

		<p>The facility offers the flu vaccine and consent forms were sighted. Vaccines are not stored on site.</p> <p>There are no residents who self-administer medications at the time of audit. The RN advises this is not allowed for safety reasons.</p> <p>Medicine errors are required to be reported via the incident reporting system.</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>	PA Low	<p>The food service is provided on site by two cooks who share the working week, with the assistance of supporting staff. A four week seasonal rotating menu is used. Records are not available to demonstrate that this menu has been approved as meeting recognised nutritional guidelines for older people. (Refer 1.3.13.1)</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service will be lodging a group food safety plan as part of a consortium of aged residential care facilities and is aware of the timeframes to do so (before 31 May 2018).</p> <p>Refrigerator and freezer temperatures are monitored daily. Food is appropriately labelled and stored. The cooks have undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan which includes a soft diet option, morning and afternoon snacks to support residents requiring a modified diet. Evidence of resident satisfaction with meals was verified by most residents and family members interviewed, satisfaction surveys and residents' meeting minutes. One resident and family member did not like some of the meals choices provided.</p> <p>Nutritional supplements are available as required / prescribed. Enteral feeding can be facilitated if required. Thickeners are available to thicken fluids for resident safety.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>There is food available 24 hours a day for residents in the dementia unit. This was verified by the HCA interviewed and documentation in residents' files that noted food and beverages provided to residents overnight or between meals.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria, or has care needs that cannot be safely met by staff, the prospective family are advised, and offered the contact details of another</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.		facility nearby. On occasions, residents are admitted to the dementia unit while awaiting for a vacant bed at the assessed level of care (refer to 1.3.1.4). The local NASC is also advised, where applicable, to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change, the facility manager advises a referral for reassessment to the NASC is made and two examples of this were sighted. There is a clause in the access agreement related to when a resident's placement can be terminated, and this information is also included in the information provided to prospective residents and family.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, pressure area risk assessment tool, nutritional screening and depression scale, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. Residents have interRAI assessments completed by one of three trained interRAI assessors on site, however not all residents have had assessments completed with 21 days of admission (refer to 1.3.3.3). There is a wound assessment and wound management plan; however, the identification, assessment, intervention and evaluation for wounds is not documented in one resident's applicable sampled files. (Please refer to criterion 1.3.5.2). Residents and families confirmed their involvement in the assessment process. Medical and allied staff document assessments, interventions and evaluations as a component of the progress notes.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Long term care plans are in use and reviewed at least six monthly. Some are dated as being developed before the interRAI assessment has been reviewed and updated (refer to 1.3.3 / 1.3.3.3) Short term care plans are used, although examples were sighted when these had not been developed. Care plans evidence service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported their participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The focus on meeting a diverse range of resident's individualised needs was evident in service provision. The GP interviewed verified that medical input is

and appropriate services in order to meet their assessed needs and desired outcomes.		<p>sought in a timely manner, that medical orders are followed, and that staff provide good communication between residents, family and health professionals. The GP reported that overall, an appropriate level of care is provided. Residents are seen six weekly by the podiatrist if clinically necessary, or otherwise if requested by the resident / family with prior consent about charges. Care staff confirmed that care was provided as outlined in the resident's file documentation and discussed at handover.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities co-ordinator who supports residents Monday to Friday from 10 am to 4.00 pm. The activities coordinator has completed a Health and Rehabilitation Course (Level 7) via Waiariki Institute of Technology, graduating in 2015.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to all the residents. The resident's activity needs are evaluated monthly and six monthly as part of the formal six-monthly care plan review. Records of attendance are maintained daily.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through day to day discussions with residents, satisfaction surveys, the audit of activities programme (November 2017) and residents' meetings. Families are supported to take their family member on outings to help attend to their cultural and spiritual choices. Residents and families interviewed confirmed residents are supported in their individual needs and find the programme provided at the facility interactive. The residents reported that they look forward to the activities of their choice and are not compelled to participate in activities if they do not want to. A range of one on one activities occur for residents who prefer this. The residents and family expressed satisfaction in the activities options available.</p> <p>The activities programme for the current and next month is displayed on the notice board by the nursing station.</p> <p>The activities co-ordinator interviewed reported that she encourages residents to attend the planned activities. Rest home and hospital level care residents mix regularly in the dining room for meals and in the lounge and dining room when activities are occurring. Activities are planned within the dementia unit normally in the morning. Residents from the dementia unit also participate in the group activities and entertainment programmes in the main hospital area with direct supervision. Cupboards containing appropriate activities supplies were sighted.</p>

		<p>For residents with the dementia unit, a 24-hour plan includes the activities that can be undertaken with individual residents throughout the 24 hour period.</p> <p>There are facility cats present. These walk around the facility providing companionship to some of the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Aspects of residents' care is evaluated on each shift by caregivers and reported on designated forms. This includes maintaining behavioural monitoring charts, verifying hourly checks have been completed, monitoring fluid and food balance charts, and urinary and bowel output where applicable for individual residents. The Bristol stool chart is used to evaluate residents' bowel functions. Registered nurses normally document at least every day within the progress notes or sooner where clinically indicated. The health care assistants advise they alert the RN on duty if there is any change in the resident's condition.</p> <p>Evaluation of the care plan occurs at least every six months, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, and for the majority of residents' wounds. The exceptions are noted in 1.3.5.2. When necessary, and for unresolved problems, long term care plans are added to or updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP, RN or CM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to palliative care services. The Hospice nurse visited on the day of audit and noted she visits normally weekly or sooner if required. A RN was observed making a new referral (via phone and in writing) to Hospice services during the audit. A wound care specialist had provided input into the wound care plan for one resident whose records were reviewed. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Residents and/or family are consulted about any plans for referral as verified by interviews and in resident notes.</p> <p>One resident with significant weight loss has not been referred to a dietitian (refer to 1.3.3).</p>
Standard 1.4.1: Management	FA	Staff follow documented processes for the management of waste and infectious and hazardous

<p>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>substances. Appropriate signage is displayed where necessary. There are four cylinders of liquid petroleum gas (LPG) stored outside the kitchen area and the location test certificate was sighted (Expires 31 March 2020). An approved handler is not required as the service provider does not connect or disconnect the LPG cylinders. All handling of the LPG cylinders is completed by the applicable LPG gas provider.</p> <p>An external company is contracted to supply and manage chemicals and cleaning products and they also provided relevant education/training for staff. Material data sheets and product information were available where chemicals were stored and utilised. Staff interviewed knew what to do should any chemical spill/event occur. A spill kit was available and accessible if needed.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness dated expiry 03 April 2019 was sighted and displayed in the nurses' station.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current (March 2018) as confirmed in documentation reviewed. The equipment inventory sighted reflected that all checks undertaken are completed by a contracted service provider. Efforts are made to ensure the environment is hazard free and that residents are safe and independence is promoted at every opportunity.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance is required. Any requests are appropriately actioned, and residents and family members were pleased 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</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The secure dementia service is a separate service and there are three showers/toilet/bathroom areas though only two of the three bathrooms are regularly used. These bathrooms are situated in close proximity to the residents' own rooms. There are eight rooms with ensuite bathrooms/toilet and vanities. All rooms have a vanity in each individual room.</p> <p>In the rest home/hospital, there are four rooms with own ensuites and three other showers/toilets/bathrooms are available for residents to use that are located close to their individual rooms.</p> <p>There are separate designated toilets for service providers or visitor use.</p>

hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate personal space provided to allow residents and staff to move freely around within their bedrooms safely in the hospital/rest home. The secure dementia unit smaller rooms. No residents are using walking aids as all residents are currently mobile. Rooms are personalised with furnishings, photos, paintings and other personal effects displayed to promote a homely atmosphere. There is adequate room to store mobility aides, wheel chairs, hoists and mobility scooters if needed. There are two hoists, a standing and a transfer hoist, available. All staff receive training in hoist management. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There are two lounges, one in the rest home/hospital and one in the secure dementia service. There is a separate dining room in each service area. Activities can be held in each lounge and/or dining rooms as needed. The rest home/hospital has easy access for residents and staff. Residents can access areas for privacy if required. Furniture sighted was comfortable and appropriate to the setting and meets the residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Residents' personal laundry is undertaken onsite in a small but functional laundry. All other laundry is collected by the preferred provider. The linen is collected three times a week. Staff put all clean linen away when delivered back to the service into the linen cupboards provided. The company contracted to provide all laundry and cleaning products also provides education to the staff. Products are also monitored for effectiveness. There are wall mounted dispensers and labelled containers are used at all times. The trolley used for cleaning the facility is kept in the laundry when not in use. A spill kit is available if required. Material data sheets are available in the laundry and the sluice room for staff to access if and when required. Care staff interviewed had good knowledge of the laundry and cleaning processes, dirty clean flow and handling of soiled linen. Personal protective equipment was readily available.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current evacuation plan was approved by the New Zealand Fire Service 28 January 2014. The last fire drill was held 15 March 2018. The report was reviewed, and positive feedback was provided by the fire service. There was a good staff attendance. A pandemic box is set up in readiness for an infection outbreak. All resources are</p>

response during emergency and security situations.		<p>checked on a regular basis. Staff interviewed 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 gas for gas cooker/barbecue are available. Emergency lighting is available and is tested as part of the regular fire compliance programme and recorded. There is a 4000-litre water tank also available if needed.</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.</p> <p>There is closed circuit television (CCTV) and the side gates to the facility are closed at all times. Evening and night time security is managed by the staff. There is a bell to alert staff for visitors when the front doors are locked at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas have opening external windows. The main dining room has external doors to a deck area and ramp to ground level. There are heat pumps in the main lounge and the dining room areas and all wings have electric wall heaters. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors. Policies and procedure are available to staff, and personal protective equipment is readily available and observed to be used appropriately. Staff are aware not to come to work if they are sick. A sign alerts visitors not to visit if they are unwell. The goals for the Solemar infection control programme have not been identified / documented or approved. (Refer 3.1.3)</p> <p>The clinical manager is the designated IPC coordinator whose role and responsibilities are defined in a job description. Any infection issues, including monthly surveillance results, are reported to the facility manager.</p> <p>Residents are offered annual influenza vaccinations and are encouraged with hand hygiene and other practices to minimise the spread of infection.</p>
Standard 3.2: Implementing the infection control programme	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role. The clinical nurse manager has completed training as verified in the training records. The</p>

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		<p>infection control team at the DHB is available and expert advice can be sought from the community laboratory and/or the GP. The coordinator has access to resident's records and diagnostic results to ensure timely treatment of any infections. The DHB wound care nurse specialist is utilised for specialist wound care advice where applicable, as sighted.</p> <p>The CM confirmed at interview the availability of resources to support the programme and any outbreak of an infection. An emergency kit with PPE supplies is available in the event of an outbreak. There have been no outbreaks since the previous audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>New infection prevention and control policies have been recently obtained from an external quality consultant and reflect the requirements of the infection prevention and control standard. These policies have yet to be reviewed to ensure the content is relevant and localised to reflect the needs and goals of this service (refer to 3.1.3).</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The staff education plan for 2018 includes infection prevention and control. An attendance record is maintained by the facility manager and the business owner. There is also an infection prevention and control online course provided by the Ministry of Health (MoH) that can be completed by staff. This has been completed by the clinical nurse manager. Infection prevention and control principals are included in other education provided to staff, including wound management and continence. Healthcare assistants confirmed infection prevention control issues are also discussed at staff meetings or shift handover as appropriate.</p> <p>Education to residents and family members occurs as required. In particular, hand hygiene and oral hygiene is encouraged, as well as annual influenza vaccinations for which prior consent is obtained from the resident or EPOA / welfare guardian.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for a long-term care facility with infection definitions noted. This includes urinary tract infections, fungal, eye, skin infections, such as scabies, upper and lower respiratory and gastro-intestinal infections. When an infection is identified a record of this is documented on the infection reporting form. The clinical manager reviews all infections. Surveillance data is collated monthly and analysed to identify any trends, possible aetiology and required actions if necessary. The results of the surveillance programme are shared with staff at monthly meetings and shift handovers. Graphs are produced that identify any trends. A summary identifies the resident's name, date of infection, type of infection, results of laboratory investigations (if completed), and summary of treatment provided. Infections and any required management plans are discussed at handover, to ensure early intervention occurs. Short term care plans were developed and sighted in applicable residents' files. There have been no outbreaks of infections since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The restraint coordinator was not present for this audit. The clinical manager was available to assist with the audit and understood the policies, procedures and practice and the responsibilities involved.</p> <p>On the day of audit, three residents all hospital level care, were using restraints. No residents were using enablers. As stated in the policy sighted, enablers are the least restrictive and used voluntarily at a resident's request, if competent to make a decision.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint records reviewed including care plans for those residents who have approved restraints, and from interview with staff.</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 (including policy and procedure), duration of restraint, and ongoing education on restraint use and</p>	FA	<p>The restraint approval group is made up of the restraint coordinator who was not available for interview. The job description was sighted, and the manager interviewed. Both sign and date the approval for restraint minimisation and safe practice for each individual resident. It was evident from review of the restraint approval group meeting minutes, review of residents' records and interview with the clinical manager that there are clear lines of accountability that all restraints have been approved, and the overall use of restraint is monitored and analysed.</p> <p>Evidence of family involvement in the decision making as required by the organisation's policies and procedures was on record in each case and the use of restraint is included in the care planning process and documented in the plan of care.</p>

this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	PA Moderate	<p>Assessments tools and an assessment for restraint/enabler use was reviewed in the policy/procedure documentation reviewed and met the requirements of the Standard. There was however, no initial assessment or assessment forms completed in the three residents' records reviewed who were using restraint. Only the consent form was sighted, signed by the GP and family/EPOA and the restraint coordinator and/or the facility manager. The family confirmed their involvement. The GP has involvement in the final decision on the safety of the use of restraint. The senior staff could not understand why the assessments were not completed as per the policy which was in the front of the restraint register. No underlying cause, history of restraint use, cultural considerations, alternatives and/or associated risks were documented.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the clinical manager described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as use of sensor mats and low beds, are explored before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records reviewed contain the necessary details, access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained and updated regularly at each approval meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraints is to be minimised and how to maintain safe use was confirmed.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	PA Low	<p>Review of residents' records evidenced the use of restraints is reviewed and evaluated during the care plan and interRAI reviews, six monthly evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The clinical manager interviewed showed that a review date is documented and some comments are made, but no details are documented to evidence that a full evaluation has occurred addressing the requirements of the standard. There was a restraint minimisation and safe practice evaluation form</p>

		available in the policy manual reviewed, but this was not completed by the registered nurse restraint coordinator or facility manager in the three residents' records reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>The restraint committee undertakes a six-monthly review of all restraint use. A report is developed and reported to the staff/quality meetings. Minutes of the meeting confirmed this occurs. The type of restraint used and the number of residents requiring a restraint in the facility is low. Any changes in policy and guidelines would be advised by the contracted quality consultant.</p> <p>The evaluation form as referred to in (2.2.4.1) still requires implementation/completion to capture all information required to meet this standard. Data reviewed, minutes of meetings and interviews with care staff and the clinical manager confirmed that the use of restraint has been reduced over the last year.</p> <p>The education plan was reviewed for all staff and restraint education with a focus on de-escalation is provided at orientation for all new staff and is ongoing.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	<p>PA</p> <p>Moderate</p>	<p>There are processes implemented to ascertain the resident's wishes in respect to cardio pulmonary resuscitation. The choice for every patient is communicated to staff via a designated communication sheet. The 'not for resuscitation' forms includes an area for the general practitioner (GP) to verify competency of the resident in decision making. The resuscitation decision forms have been completed by family members who hold enduring power of attorney for at least eight of the 11 residents' files sighted. One form was not signed by the resident or family member. The GP had noted the resident was not competent.</p>	<p>Persons with Enduring Power of Attorney status are signing not for resuscitation decisions for residents that are not competent to make their own decisions.</p>	<p>Ensure that residents' Enduring Power of Attorney are not signing the resuscitation decision form on behalf of residents, and that only competent residents are involved in this decision making.</p> <p>90 days</p>

<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Any adverse events, incident/accidents or untoward events are clearly documented on the appropriate form sighted. Any shortfalls provide an opportunity to identify and manage any risk and to improve service delivery. Once the information gathered monthly is collated and analysed, actioned and any quality initiatives are developed and implemented the incident/accident forms, if resident related, are to be placed in the resident's individual record. This has not occurred since June 2017. The forms sighted are in the incident/accident folder reviewed and not in the individual resident's record. There is no evidence of an incident log in any of the resident's records reviewed. A monthly incident/accident analysis form was kept in the incident/accident folder reviewed. The name of the resident, the place of the incident, date, time of day, witnessed or unwitnessed, injury sustained if any, injury site, cause if known and the GP notified is all documented. A summary sheet is completed at the end of the form sighted with any problems identified and action taken or to be taken being documented.</p>	<p>The incident/accident completed forms are not filed in the individual resident's records and an incident log is not maintained in the resident records reviewed as per the incident/accident policy reviewed.</p>	<p>Ensure the original incident/accident forms once relevant information is collated and analysed are filed appropriately in the individual resident's record and that an incident/accident log is maintained in each resident's record as per the policy reviewed.</p> <p>180 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA High	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. One resident does not have a signed admission agreement in place. The resident was living in the rest home when the owner purchased the facility in June 2017. The resident has</p>	<p>There is one rest home level resident and two hospital level care residents who are being cared for in the secure dementia unit.</p>	<p>Ensure only residents who have been assessed as requiring dementia level care are admitted to and cared for in the secure dementia care unit.</p> <p>30 days</p>

		<p>diminished competence, and next of kin do not live locally. Due to circumstances, the Solemar owner has been liaising with the Public Trust in an attempt to have an enduring power of attorney appointed, and these email communications were sighted. Service charges comply with contractual requirements.</p> <p>There are three residents currently living within the secure dementia unit that have not been assessed as requiring secure dementia care. One of the residents was admitted earlier in the week of audit. The resident and two family members interviewed verified they were informed by the facility manager that the available bed was located in the secure dementia unit. They were happy for this admission to occur on the stated understanding the resident would be relocated to the hospital wing as soon as the next bed became available (expected to be within two weeks). Another resident assessed as rest home level care is living in the secure dementia unit. The clinical manager (CM) advises this was at the resident's request, as there is another resident that he talks with / gets along well with. A referral (this is not dated) is on file to NASC to ask for a re-assessment of this resident to dementia level care. The CM advises this was verbally declined by NASC. Another resident in the dementia unit has a needs assessment on file identifying hospital level care is required. The CM understood the resident had been assessed as requiring secure dementia level care. This resident had previously been in an ARC facility until being hospitalised at the DHB hospital. On discharge from the DHB, the family member advised the resident was reassessed as requiring hospital level care. The family member was aware that the resident was residing in the secure dementia care and was not unhappy with this. The family member reported no hospital level care beds were available at the time of admission to Solemar and the family member felt the resident was safer in the secure unit due to their cognitive impairment.</p> <p>One other resident's file reviewed, noted the resident had been temporarily relocated to the secure dementia unit for a</p>		
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		short while (timeframe not clear), while maintenance occurred within the resident's normal bedroom.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>The notice displayed in the medicine room notes there are 11 healthcare assistants (HCAs) who are competent to check controlled drugs, five staff who are competent to administer oral medicines and seven staff who are competent to check insulin doses. This does not correlate with the information sighted in the staff personnel files. Three RNs and three HCAs have a current medicine competency assessment on file. All of the HCA personnel and training records were reviewed by the lead auditor.</p>	<p>The medicine competency records reviewed in staff records did not correspond with the list of staff identified as competent displayed in the medicine room.</p>	<p>Ensure that all staff responsible for checking or administering medicines have current competencies and this information is communicated accurately.</p> <p>90 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>The summer menu is in use. This is a four-week rotating menu that details the food items provided for the three meals and the morning and afternoon tea and supper. The main meal is provided at lunchtime. Records were not available to demonstrate that this menu has been reviewed by a registered dietitian or otherwise verified as meeting recognised nutritional guidelines for older people. The facility manager advises a dietitian review has been conducted, however the associated records could not be located.</p>	<p>Records are not available to verify that the service menu plans have been reviewed by a dietitian.</p>	<p>Ensure records are available to demonstrate that menu plans have been reviewed and approved by a dietitian.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely</p>	<p>PA Moderate</p>	<p>An initial nursing assessment of the resident is required to be undertaken, and care plan developed within 24 hours of an admission. This is not consistently occurring. Three out of seven residents admitted since June 2017, and whose files were reviewed, had incomplete initial nursing assessments on file. Two residents' initial nursing</p>	<p>One resident has had an interval of four and a half months between reviews by the</p>	<p>Ensure a system is in place to consistently ensure residents are reviewed by the general</p>

meet the needs of the consumer.	<p>assessments were dated as occurring two days after admission, and one of these is included in the incomplete sample. Initial care plans have been developed within 24 hours for two of the residents whose files were reviewed. For two residents the initial care plan was dated two days after admission, for one resident the initial care plan was dated as developed three days after admission, and for one resident the initial care plan dated was developed eight days after admission. The initial care plan for one resident could not be located (including in the resident's archived records).</p> <p>Long-term care plans are required to be developed within three weeks of admission. This timeframe was met for five of the seven residents whose files were reviewed. The initial long-term care plan for one resident could not be located including in the electronic word files (used when plans are developed), as well as archived paper records. One resident has been admitted for less than 21 days as at audit. The other four residents whose files were reviewed were admitted prior to the change in facility ownership.</p> <p>Care plans developed are based on a range of clinical assessments, including original and/or reviewed interRAI assessments, referral information, resident and family input and the NASC assessments. Two of the seven residents admitted since June 2017 have not had updated interRAI assessments completed within 21 days of admission. The CM reported the resident's needs had not changed. One other resident has been admitted for less than 21 days.</p> <p>Long term care plans sighted detailed strategies to maintain and promote the resident's independence, wellbeing and, where appropriate, their community involvement, although some are dated as completed before the subsequent interRAI assessment was completed (refer to 1.3.5.2).</p> <p>A medical assessment is undertaken within two working days (excluding weekends and public holidays), of admission and this had been completed. Ten of the eleven residents have been reviewed as their condition changed,</p>	<p>general practitioner. There is no system to identify when routine general practitioner reviews are due.</p> <p>Four residents' initial nursing assessments have not been completed within 24 hours of admission.</p> <p>Five residents did not have an initial care plan developed to guide care within 24 hours of admission, or the initial care plan could not be located.</p> <p>Two residents admitted in 2018 have not had an interRAI re assessment completed within 21 days.</p> <p>A dietitian referral has not been initiated for a resident with a weight loss of 10</p>	<p>practitioner at the frequency documented as required (at least every three months).</p> <p>Ensure initial nursing assessments are undertaken and an initial care plans developed for all residents within 24 hours of admission</p> <p>Ensure an InterRAI reassessment is conducted within 21 days of admission.</p> <p>Ensure referrals are made to the dietitian in a timely manner for applicable residents.</p> <p>90 days</p>
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<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Three different templates were sighted in use in residents' files for the documenting of long term care plans. The CM advised one standardised template is now being used for new residents and for when plans are updated. The most recent long-term care plans of at least four of the residents reviewed are dated as being developed before the interRAI re-assessment had been completed (refer to 1.3.3.3). Despite this, the family members interviewed confirmed the</p>	<p>Short term cares plans have not been developed for a resident with significant weight loss.</p> <p>One resident was admitted</p>	<p>Ensure short term care plans are consistently developed for new short-term care needs.</p> <p>Ensure wound care plans are</p>

		<p>residents' needs are being met.</p> <p>Individualised plans of care are developed for the residents within the dementia unit that covers a 24 hour period. In addition, an individualised activities plan is developed for every resident.</p> <p>Short term care plans have been developed for temporary needs, including related to infections, skin tears, shortness of breath, pressure injuries and other types of wounds / skin tears. The wound care plans sighted were detailed and included assessment, interventions and evaluations within the template. One resident admitted with two wounds (as detailed in the admitting RN's progress notes), did not have a wound care plan present for either wound. One of the residents audited using tracer methodology has had a significant weight loss of 10 kilograms over eight months. While interventions have occurred, including the resident being reviewed by the GP and commencing a nutritional supplement, and family members assisting with encouraging the resident to eat, a short term care plan has not been developed. The resident's family member stated she had been kept informed by staff of the weight loss and had been assisting staff by encouraging the resident to eat more. A referral to the dietitian has not occurred (refer to 1.3.3).</p>	<p>with two wounds. Wound care plans were not documented for these wounds.</p> <p>At least four residents' long term care plans were developed or updated before the interRAI re-assessments were completed to inform the care plan requirements.</p>	<p>consistently documented for residents with wounds.</p> <p>Ensure the outcome from the interRAI reassessments are undertaken in a timeframe to inform changes required to the resident's long term care plans.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	<p>The service has recently obtained new infection prevention and control policies and procedures from an external consultant and has yet to develop specific infection prevention and control related goals for this service, and to have the plan signed off by the manager.</p>	<p>The service has yet to develop infection prevention and control goals for the service and to have the plan signed off by management.</p>	<p>Ensure the infection prevention and control programme is developed, approved and signed off by management and reviewed</p>

				<p>annually.</p> <p>180 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	<p>PA</p> <p>Moderate</p>	<p>The records of the three residents using a form of restraint were reviewed. Records did evidence possible alternative interventions and techniques for de-escalation had been documented in the respective long-term care plans reviewed. The clinical manager was interviewed to explain the assessment process. There was no evidence of any initial restraint assessment or assessment forms being completed by the registered nurses as per the restraint minimisation and safe practice policy reviewed.</p>	<p>The residents' records of three hospital residents currently using a restraint were reviewed. There was no evidence of any assessment being completed to identify any risks, cultural considerations or any history or underlying aetiology for managing any relevant behaviour issues if known prior to any restraint being put in place.</p>	<p>Ensure all residents are comprehensively assessed using the required assessment tool and that the required documentation is completed before restraint is used as a last resort.</p> <p>90 days</p>
<p>Criterion 2.2.4.1</p> <p>Each episode of restraint is evaluated in collaboration with the consumer and</p>	<p>PA Low</p>	<p>The three residents using a restraint are being evaluated in a timely manner as per the restraint minimisation and safe practice policy reviewed. The evaluation forms observed in</p>	<p>The restraint evaluation forms completed by</p>	<p>Ensure the appropriate evaluation form</p>

<p>shall consider:</p> <p>(a) Future options to avoid the use of restraint;</p> <p>(b) Whether the consumer's service delivery plan (or crisis plan) was followed;</p> <p>(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);</p> <p>(d) Whether the desired outcome was achieved;</p> <p>(e) Whether the restraint was the least restrictive option to achieve the desired outcome;</p> <p>(f) The duration of the restraint episode and whether this was for the least amount of time required;</p> <p>(g) The impact the restraint had on the consumer;</p> <p>(h) Whether appropriate advocacy/support was provided or facilitated;</p> <p>(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;</p> <p>(j) Whether the service's policies and procedures were followed;</p> <p>(k) Any suggested changes or additions required to the restraint education for service providers.</p>		<p>the individual records do not cover all the requirements to meet the restraint minimisation and safe practice standard. An evaluation form was available, which was reviewed 1 September 2017, but this has not been completed/implemented.</p>	<p>the registered nurse for the residents using a restraint do not contain all the requirements of the restraint minimisation and safe practice standard documented in this criterion. The evaluation forms, as per the restraint minimisation and safe practice policy, have not been completed.</p>	<p>is completed as per the restraint policy used by the organisation.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.