

# Aberleigh Rest Home Limited - Aberleigh Rest Home

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:** Aberleigh Rest Home Limited

**Premises audited:** Aberleigh Rest Home

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

**Dates of audit:** Start date: 5 April 2018 End date: 5 April 2018

**Proposed changes to current services (if any):** The eight-bed unit (Totara) assessed at the previous partial provisional audit as suitable for dementia care, then subsequently reconfigured (with approval from HealthCERT) to dual-purpose bed hospital/rest home remains vacant. The unit was reviewed as part of this audit as suitable as a dual-purpose rest home /hospital unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 39

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# Executive summary of the audit

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## 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

Dementia Care New Zealand Ltd (DCNZ) is the parent company of Aberleigh Rest Home. The service provides care for up to 62 residents across four service levels (psychogeriatric, hospital, rest home and dementia). On the day of audit, there were 39 residents.

The service is managed by an operations manager (non-clinical) and a clinical manager, who have both had several years' experience in their roles. They are supported by a stable workforce and company directors and DCNZ organisational management team. Family and residents as appropriate, all spoke positively about the care and support provided.

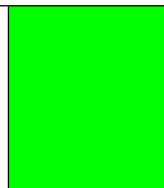
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff. As part of this audit the eight room Totara unit was verified as suitable to provide rest home/hospital level care. This unit is currently vacant.

The service has addressed two of three findings from the partial provisional audit in regard to progress notes and the Totara unit.

The previous finding around registered nurse staffing for the psychogeriatric unit remains.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

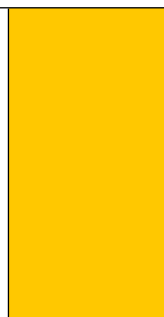


Standards applicable to this service fully attained.

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. Family members are informed in a timely manner when their family members health status changes. A site-specific introduction to the dementia unit booklet provides information for family, friends and visitors to the facility. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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 medium or high risk and/or unattained and of low risk.

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. Aberleigh has a current business and quality plan to support quality and risk management at each facility. Aberleigh implements an internal audit programme and collates data for comparisons against other Dementia Care NZ facilities. Incidents and accidents are appropriately managed. The service has a documented

annual training plan. The service has an orientation programme in place. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were based on the interRAI outcomes and other assessments. They were clearly written, and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community nurse as required. The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans have been developed in consultation with resident/family.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. There are regular visits and support provided by the community mental health team and psycho-geriatrician.

The food services are provided from the main kitchen and delivered in hot boxes to the small home kitchenettes. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period. There is dietitian review and audit of the menus. All staff have been trained in food safety and hygiene.

## Safe and appropriate environment

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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. On the day of the audit there was one resident using a restraint (H belt) and there are no residents with enablers. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Dementia Care NZ (DCNZ) facilities.

## 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	16	0	0	1	0	0
Criteria	0	39	0	0	1	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. There are complaint forms and information available at the entrance. Information about the complaints process is provided on admission. Eight care staff interviewed (six caregivers, one registered nurse (RN) and one diversional therapist) were able to describe the process around reporting complaints. An established complaints register is included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response.</p> <p>Five complaints received in 2017 were reviewed. All complaints reviewed have documented investigation. Timeframes for addressing each complaint are compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) are documented. All lodged complaints are documented as resolved. An additional complaint made in 2018 through the HDC was reviewed during the audit process, a response letter sent by Aberleigh on 5 February 2018 had not received a response from HDC at the time of the audit.</p>
Standard 1.1.9: Communication  Service providers	FA	<p>There is an open disclosure policy in place, information on which is included at the time of admission. Three residents (one hospital and two rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A site-specific introduction to the dementia and PG unit booklet provides information for family, friends and visitors to the facility. Accident/incidents, complaints procedures</p>

communicate effectively with consumers and provide an environment conducive to effective communication.		and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Ten incidents/accidents forms were reviewed. All incident/accident forms reviewed indicate family are informed. Three relatives (one hospital, one rest home and one dementia care) interviewed, confirmed they are notified of any changes in their family member's health status.
<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>Aberleigh Rest Home provides care for up to 62 residents across four service levels (hospital [medical and geriatric], rest home, psychogeriatric and dementia level care). On the day of audit, there were 39 residents in total, 14 residents across the two 10-bed dementia units; six residents in the six-bed psychogeriatric (PG) unit (including one resident under of age of 65), 10 hospital residents and nine rest home level residents in the 36-bed dual-purpose hospital/rest home unit. There were no residents on respite care or on medical contracts. All other residents were on the age-related contract.</p> <p>Dementia Care NZ has a corporate structure in place which includes two directors and a governance team of managers and coordinators. The operations management leader and national clinical manager support the operations manager and the clinical manager respectively. The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p> <p>There is strategic plan for 2015-2018 and a business plan for 2017-2018 in place for all DCNZ facilities. The 2017 organisational goals have been reviewed by the governance team, company clinical director, quality systems coordinator and company educator/psychiatric RN.</p> <p>An operations manager and a clinical manager oversee Aberleigh Rest Home daily. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the national clinical manager who reports to the clinical director. The operations manager has been in the role for three years and has worked at DCNZ for eight years. The clinical manager is responsible for the clinical oversight of the service and has been in the position for four years. An organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company educator/psychiatric RN and directors regularly visit the facility and provide support to the team at Aberleigh Rest Home. At the time of the audit the company educator/psychiatric trained RN was present.</p> <p>The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and twice yearly for all clinical managers.</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-wide quality and risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management plan is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained, and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided at the monthly quality meeting. Staff interviewed confirmed involvement and feedback around the quality management system. Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected. The service has policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly.</p> <p>The internal audit schedule for 2018 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management. The organisation's annual resident/relative satisfaction survey for 2017 has been delayed until 2018 due to process changes. Overall results report that residents and relatives are satisfied with the service. Falls prevention strategies are in place that includes assessment of risk, medication review, assessments with physiotherapy input and exercises/physical activities. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Ten incident forms reviewed identified they were fully completed and followed up appropriately by the RN. Minutes of the monthly quality meeting, health &amp; safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. Discussions with the operations manager and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed since the last audit. A norovirus outbreak in January 2018 had been notified to the public health authorities.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Five staff files sampled (one clinical manager, one operations manager, one RN, one caregiver and one diversional therapist) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. There is an education planner in place that covers compulsory education requirements and includes programmes designed and implemented by the service.</p> <p>There are 28 caregivers employed across the two dementia units and the PG unit, twenty-four have completed the required dementia unit standards. Four caregivers are in the process of completing and all have been employed for less than 12 months. The "best friends approach to care" programme is designed to support caregivers and RNs to adapt a best friend approach to residents with dementia. Regular "best friends approach to dementia care" (putting yourself in their shoes) training is carried out for all staff. There are four RNs and three have completed interRAI training. The clinical manager has also completed interRAI training. Clinical staff complete competencies relevant to their role.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, including for dementia and psychogeriatric level care. Rosters are published for staff. The operations manager and the clinical manager are on-site full time and available afterhours. There is a RN on duty 24/7 in the dual-service hospital/rest home unit. The previous audit identified that there is no specific RN allocated to the six-bed psychogeriatric unit as specified by the ARHSS contract. The service continues to consider ways to address this issue and the finding remains.</p> <p>The two 10-bed dementia units (Rata unit, there are nine residents and Matai unit, there are five residents) are managed on a day-to-day basis by home managers (senior caregivers). In each unit there is one home manager and one care giver on a short morning shift shared between both units. One caregiver on the afternoon shift and one caregiver on the night shift. An RN is based in the six-bed psychogeriatric unit (Ngaio) and provides clinical oversight across the three units during the day.</p> <p>In the six-bed psychogeriatric unit (Ngaio) there is one RN and one home manager on the morning shift, one caregiver (on the afternoon shift. There is also a caregiver that is rostered as a 'floater' on the morning and afternoon shifts to work where required. There is one RN on night shift.</p> <p>In the 36-dual-purpose bed hospital/rest home unit (Koromiko wing, there are eight rest home and two hospital residents, Kowhai, there are one rest home and eight hospital residents and Totara wing, there are no residents). There is a RN on duty on the morning and afternoon shifts, and on the night shift. The RNs are supported by four caregivers on the morning and afternoon shifts, and two caregivers on the night shift.</p> <p>Residents and family interviewed praised the staff and the level of staffing. Interviews with caregivers, residents</p>

		<p>and family members identified that staffing is adequate to meet the needs of residents.</p> <p>Caregivers interviewed stated the roster is filled when staff are off sick and that there were sufficient staff rostered.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in one main medication/nurses station. Registered nurses only administer medications in the hospital and psychogeriatric units. Caregivers administer medications in the rest home and dementia care units. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all regular and 'as required' medications. The RN on duty reconciles the delivery of the robotic packed medication and this is evidenced on the resident charts on the electronic medication system. Stock is checked monthly for expiry dates. All eye drops had been dated on opening. The medication fridge temperature is monitored daily. There were no residents self-medicating.</p> <p>Twelve medication charts (two rest home, two hospital, four dementia and four psychogeriatric care) on the electronic medication system were reviewed and all prescribing and administration met legislative requirements. Medical practitioners review the medications charts three monthly. The psychogeriatric service review the use of antipsychotic medications.</p> <p>There is one centrally located nurses station and medication room for the facility.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There are two qualified cooks that cover seven days. They are supported by afternoon kitchenhands. The dinner meal is the main meal of the day with a light lunch. Meals are placed into containers and delivered in hot boxes to the 'home' kitchenettes for serving. The cook plates any special diets. Soft/pureed meals and diabetic desserts are provided. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Resident likes, and dislikes are known, and alternative foods are offered. There were adequate fluids sighted in the kitchenette fridges. Nutritious snacks were available 24 hours in the dementia and psychogeriatric 'homes'. This was confirmed by care staff working in the areas.</p> <p>There is daily monitoring of hot food temperatures, fridge and freezer temperatures. A cleaning schedule is maintained. The dry good store has all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. The food control plan was submitted to the council March 2018.</p> <p>Residents and the family members interviewed were very happy with the quality and variety of food served.</p> <p>The Totara dining room is large enough for dual-purpose residents and equipment.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at each handover. When a resident's condition changes the RN initiates a GP or nurse specialist consultation. If external medical advice is required, this will be actioned by the GPs. There is specialist input into the residents' care in the psychogeriatric unit. The community mental health/psychiatric nurse visits at least weekly and liaises closely with the clinical manager/RN, GP and the psycho-geriatrician based at the DHB. There is evidence in the medical notes of GP communication with the psycho-geriatrician in regard to medication review.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>There were six wounds and one stage two facility acquired pressure injury (hospital level resident) on the day of audit. All wounds have wound assessments and have been reviewed within the documented timeframes. All wounds have short-term care plans in place. The service accesses the company wound nurse (via skype) at head office. The RNs also have access to specialist nursing wound care advice through the district nursing service.</p> <p>Behaviours that challenge have been well identified through the assessment process in the residents' files reviewed. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours. A seven-day behaviour monitoring is commenced for all new admissions to the dementia and psychogeriatric units. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment.</p> <p>Monitoring forms include pain, behaviours, observations, neurological observations blood sugar levels, weight, re-positioning charts, food and fluid and 24-hour hourly checks.</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,</p>	FA	<p>There is a qualified diversional therapist (DT) who oversees the activity programme for each 'home'. There are three DTs in training. The DT is based in the rest home/hospital 'home' and visits each 'home' daily in the mornings. Activities are seven days a week in all 'homes' with the rest home hospital from 10.00 am to 4.30 pm and from 1.30 pm - 4.30 pm in the dementia 'homes' and the psychogeriatric 'home'. Care staff on duty are involved in individual activities with the residents and there are plentiful resources available. The activity programme for each 'home' is flexible to meet the needs of the residents and include (but not limited to); exercise, movements to music, word games, music, reminiscing, newspaper reading, arts and crafts, baking, happy hours, outdoor walks and one-on-one activities.</p> <p>The activity programme for dementia and psychogeriatric residents is focused on household/meaningful tasks,</p>

and the setting of the service.		<p>reminiscing and sensory activities, walks and gardening.</p> <p>There are combined activities that all residents can participate in as appropriate, and under supervision. Regular entertainment, pet therapy (SPCA volunteer) and church services are scheduled for all residents. Other community links include Red Cross visitor programme, stroke club and friendship group through Age Concern. There are regular van outings for all residents.</p> <p>A "my profile" social history is completed on or soon after admission and information is gathered from the relative (and resident as able) and is included in the 24-hour MDT activity plan that is evaluated at least six monthly. Resident and family meetings are held.</p> <p>The programme observed was appropriate for the resident groups and older people with mental health conditions and dementia. Activities were observed to be occurring in the lounges.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Files reviewed demonstrated that the long-term care plans were evaluated at least six monthly (or earlier if there was a change in health status) for all residents. Changes in health status were documented and followed up. Reassessments have been completed using interRAI LTCF for two of six resident files reviewed who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service updated changes in the long-term care plan.</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>The building has a current warrant of fitness that expires 1 July 2018. In the previous partial provisional audit, the entry and garden/path of the Totara unit was not yet secured. However, the demand for hospital/rest home beds has increased and since the previous audit the service has decided to reconfigure the Totara unit for rest home/hospital level care. The rooms are large enough for hospital level care. There are hospital beds and adequate equipment for the increase in hospital/rest home level residents. There is a mobility bathroom available that is spacious enough for equipment. The unit is not secure, and residents and relatives can freely access the unit and the garden.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive</p>	FA	<p>There was no changes to the building and therefore the fire evacuation scheme has not required any amendments.</p>

an appropriate and timely response during emergency and security situations.		
<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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place, appropriate to the complexity of service provided. Infection control data is reported at the infection control committee and clinical RN meetings. Trends and analysis occurs. Quality improvement plans are generated for any infection rates above the NZ industry rates.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p> <p>The facility has had one outbreak in January 2018 that was well managed. Relevant authorities were notified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. A register is maintained by the restraint coordinator/RN. On the day of the audit there was one resident using a restraint (H belt) and there are no residents with enablers. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.</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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a documented staffing rational and policy in place and rosters are published for staff. Residents and family interviewed praised the staff and the level of staffing. The PG unit does not have an allocated RN rostered in the unit as per D17.3b. The service has internal staff to cover the Totara unit when it opens. A draft roster is yet to be developed for the unit.</p>	<p>(i)There is no specific RN allocated to the six-bed PG unit between the hours of 4.30pm - 10pm to meet ARHSS contract D17.3b and D17.4. (ii) The Totara dual purpose unit is not currently open and therefore a draft roster has not been developed</p>	<p>Ensure staffing meets the ARHSS contract D17.3b and D17.4 for the PG unit. (ii) Ensure a draft roster is in place prior to occupancy of the Totara unit.</p> <p>30 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.