

Portwell Care Limited - Cook St Nursing Care Centre

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:	Portwell Care Limited
Premises audited:	Cook St Nursing Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 September 2018 End date: 21 September 2018
Proposed changes to current services (if any):	Change rest home bedrooms 4, 8, 9, and 10 to dual purpose rooms. There will be no change in the total number of beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

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

Cook Street Nursing Care Centre was purchased by Portwell Care Limited in November 2017 and is privately owned. Residential care is provided for up to 30 residents. On the first day of audit there were 29 beds occupied.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and a physiotherapist.

A partial provisional audit was also undertaken to establish the level of preparedness of the provider to provide a reconfigured service. The proposed change consists of four rest home rooms to dual purpose rooms. The completion of a partial provisional audit confirmed the provider's preparedness to provide the reconfigured service.

Continuous improvement ratings have been awarded relating to palliative care, person centred care planning and activities. There were no areas requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

The facility manager is responsible for the management of complaints and a complaints register is in place. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Portwell Care Limited is the governing body and is responsible for the services provided. There is a business plan that documents vision, direction and goals. Systems are in place for monitoring the services provided.

The owners work in the business; one is a registered nurse and has the position of facility manager and the other is responsible for the overall building maintenance and sourcing of supplies and purchases. The facility manager has experience in managing other aged care facilities. The facility manager is also responsible for the clinical services and is supported by a clinical nurse leader.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff and resident meetings are held on a regular basis.

There are policies and procedures on human resources management. Human resource processes are followed. An in-service education programme is provided, and staff performance is monitored.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager is on call after hours.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers, communication sheets, key worker allocations and low staff turnover supports continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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.
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A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation. Residents' rooms have adequate personal space provided. Lounges, dining area and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. Personal laundry is washed on site, all other laundry is contracted out. Cleaning and laundry systems are audited for effectiveness.

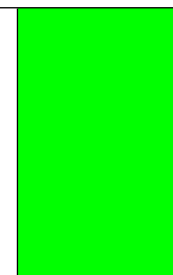
Restraint minimisation and safe practice

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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The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' needs. At the time of audit there were no residents using restraint. There were three residents using an enabler.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from an external advisor and the MidCentral District Health Board. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Cook St Nursing Care Centre (CSNCC) has policies, procedures and processes in place 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.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, and collection of health information. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available in the entrance foyers. Family members, residents and staff spoken with were aware of the Advocacy Service, how to access this and the resident's right to have support persons.</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 having the community actively involved in the goings on in the facility, attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and service improvement forms available at the entrances to the facility.</p> <p>The complaints register shows no complaints have been received since the previous audit. The facility manager (FM) is responsible for the management of complaints and confirmed this. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required. Numerous complements have been received from families since the previous audit about the high standard of care provided to their relative.</p> <p>The FM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Residents and family members 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 staff. The Code is displayed and brochures were available in common areas and entry foyers together with information on advocacy services, how to make suggestions on areas that could be</p>

their rights.		improved, and feedback forms.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed the services they received were provided in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. "Residents and families interviewed provided positive feedback about the staff, care and management."</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussions with families and the general practitioner (GP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were no residents in CSNCC at the time of audit who identify as Māori, however interviews verified that staff (some of whom identify as Maori), can support residents who identify as Māori to integrate their cultural values and beliefs if required. The concept of 'Te Whare Tapa Wha', the four cornerstones of Maori health, embraces all people from all cultures and is the philosophy by which CSNCC practices. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a comprehensive Māori health plan developed with input from cultural advisers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are</p>

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		met, and this supported 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	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<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, 'Sequel' team, district nurses, oncology services, respiratory specialists, physiotherapist, wound care specialist, community dieticians and services for older people. RNs can access training provided by the MidCentral District Health Board (MCDHB) in addition to accessing the MCDHB's online learning hub. Care staff are supported to update their knowledge with access to external training providers, access to on line training in addition to the in-service training offered on site. The facility manager (FM) is a member of the NZ College of Nurses, New Zealand Nurses' Organisation special gerontology interest group, and a member the Aged Care Residential Care forum. The FM reviews all the policies, and ensures they are in line with best practice standards. As part of the 'Sequel' project (refer criterion 1.2.3.1) the hospice nurse practitioner visits every six weeks to address any learning deficits to support the services commitment to providing quality palliative care. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to resident centred care. Staffing numbers exceeded that of safe staffing guidelines, staff were not hurried and had time to care, call bells were responded to promptly and staff were happy and verbalised they felt valued. Set regular shifts</p>

		<p>enabled work commitments to fit with family commitments and enable work life balance. Residents and families were complimentary of the care provided. The community was actively involved in the day to day functioning, for example, there was school/preschool children mingling in addition to participation in events by community groups. The facility was observed to be a 'hive of activity'. Managements' philosophy of care is committed to ensuring staff enjoyed their work and enabled residents to have the best quality of life they can (refer criterion 1.3.5.2).</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 own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed through family members, staff, or the interpreter services available through the MCDHB via Interpreting New Zealand when required. Staff knew how to access interpreter services if required.</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>Portwell Care Limited is responsible for the services provided. A business plan includes personal and facility visions, five goals with timeframes for review and includes a purpose, scope and direction. An organisational chart sets out the structure of the organisation. The owner/FM stated they are on site every day and meet with the clinical nurse leader (CNL) each day and discuss all matters pertaining to clinical governance. Both the FM and CNL stated they are in constant communication.</p> <p>The facility is managed by one of the owners who is a registered nurse with extensive aged care experience who has been in this position since taking over ownership in November 2017. There was evidence in the FM and CNLs' files of appropriate ongoing education. The facility manager is supported by the CNL/RN.</p> <p>The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service.</p> <p>The facility can provide accommodation for 30 residents. On the first day of this audit there were 29 residents. The facility has contracts with the DHB for rest home and hospital level care including medical, palliative and respite services and health recovery. Ten residents have been assessed as requiring rest home level care, 18 hospital level care, one of whom is a health recovery resident, and one private resident under the age of 65 years receiving respite care.</p> <p>The provider has made application to HealthCERT to reconfigure services from three dual purpose rooms to seven, by changing rest home rooms 4, 8, 9 and 10 to dual purpose rooms. This will result in a reduction of</p>

		rest home beds from 10 to six and an increase of dual purpose rooms from three to seven. Observations, interviews and review of documentation confirmed the provider has ensured the reconfiguration of services will not impact on the services capacity to meet the requirements of the Health and disability Services Standards and the contract with the DHB.
<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>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager be absent. The CNL is responsible for the day-to-day management of the facility during the facility manager's absence. The CNL is experienced in aged care and worked in the facility prior to the change in ownership. Support is also provided from the health centre situated opposite the facility.</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 quality and risk management system that guides the quality programme. Risk management activities are appropriate for the size and scope of the organisation. Quality data is collected, collated, analysed and corrective action plans developed in response to identified issues in a range of ways, including audits, incident/accident reports, any complaints, surveys and deficits identified from meetings. Quality data is graphed month by month and available for staff. Staff stated they discuss trends and corrective actions at the staff meetings and at handover. The FM demonstrated sound knowledge relating to quality and risk management.</p> <p>Satisfaction surveys have just gone out to residents and family and currently three have been returned and evidenced high levels of satisfaction. Quality and risk management issues are reported and discussed with the owners and at the facility wide six weekly meetings. Review of the meeting minutes confirmed this.</p> <p>There has been a focus for Portwell Care Ltd systems including policies and procedures to be imbedded and fully implemented at CSNCC and this has been achieved. Staff interviewed confirmed this and reported a smooth transition. Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice and reference legislative requirements including reference to the interRAI. Policies and procedures have footers that show they are current. New / reviewed policies are available for staff to read and sign off once read. Documentation is also discussed at the staff meetings. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery and they were advised of new policies / revised policies.</p> <p>The health and safety policy covers all aspects of health and safety management. Actual and potential risks</p>

		<p>are identified and documented in the hazard register. The register identifies hazards and risks including but not limited to clinical, environmental, staffing and financial and shows the actions put in place to minimise or eliminate risks. Newly found hazards/risks are communicated to staff. Hazards and safety issues are discussed at staff meetings. The health and safety representative is the FM who demonstrated a sound knowledge of health and safety. Staff confirmed they understood and implemented documented hazard/risk identification processes.</p> <p>A continuous improvement rating has been awarded under 1.2.3.7 relating to providing a more effective end of life experience for residents and their families.</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>Staff document adverse and near miss events on an accident/event form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the FM and trends shared with staff through meetings and on the staff notice board. Residents' families were advised of the incident/event in every form sampled.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries and health and safety issues. They advised there have been no notifications of significant events made to external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files are managed well and include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, police and visa vetting and training certificates.</p> <p>New staff are required to complete the induction programme. They are 'buddied' with an experienced caregiver for three weeks with constant support from the FM and CNL. The entire process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and yearly thereafter unless there are performance issues. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>The education programme is the responsibility of the FM and CNL. Records are held for staff attendance at training sessions and competencies for medicine management and restraint. In-service education provided for staff and documentation evidenced this is provided at least monthly. Online modules are available and clinical staff have attended the palliative care programme. External educators provide some sessions and the RNs also attend education sessions provided by the DHB. The RNs are expected to present any</p>

		<p>sessions they attend to the rest of the staff. Staff have current first aid certificates, and these were sighted in staff files.</p> <p>The Careerforce education programme is also available for staff to complete and staff are encouraged to do so. The FM is the facility assessor for the programme.</p> <p>Staff confirmed they have completed an induction, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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>	FA	<p>There is a documented process that determines the staffing levels and skill mix to provide for safe service delivery. The service is covered 24 hours per day, seven days per week and an RN is always on duty in the facility. Staffing is adjusted based on interRAI assessments for acuity and/or occupancy. 'On-call' is provided by the FM and the CNL. Rosters reviewed over a one-month period evidenced staffing levels are above the requirements of the Aged Residential Care Contract requirements. Staff interviewed confirmed they complete their work easily and residents and families stated there is always staff available in the facility. The FM and CNL work full time. Four RNs are interRAI trained as well as the FM. There are dedicated household staff including laundry and cleaning staff and the maintenance person is one of the owners. Staff are replaced in the event of planned or unplanned absences. Contracted services include a facility GP, pharmacist, physiotherapist and a podiatrist. The FM reported staffing levels will be adjusted if acuity levels increase with the change from four rest home beds to dual-purpose beds.</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>The resident's name, date of birth and National Health Index (NHI) number were used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records form part of the residents permanent records, and are archived electronically in the medication management portal.</p>
Standard 1.3.1: Entry To	FA	Residents are admitted to the CSNCC when their required level of care has been assessed and confirmed by

<p>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>		<p>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 meet with the FM or the clinical nurse leader (CNL). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the MCDHB 'pink 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, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for PRN medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p>

		<p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian - 1 September 2017. Recommendations made at that time have been implemented. A food control plan has been registered with the Ministry of Primary industries (MPI) 6 July 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The main meal at CSNCC is served in the evening with a light meal of soup and a hot dish served at lunchtime. Residents verified satisfaction with the main meal in the evening. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was enough staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the FM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>On admission, residents of CSNCC are initially assessed using a range of nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. Except for the respite resident, interRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. Five residents' files reviewed noted changes in care levels and subsequent reassessments being made.</p> <p>The electronic medication management system, is a secure portal and is used to record the effectiveness of any changes in medications and the effectiveness of any pro re nata (PRN) medication administered. Additional information other than medication data is also recorded. Residents weighs are recorded and graphed and wounds are photographed, and the photos uploaded. The GP can then review this data off site if required, and action any changes needed.</p> <p>All residents have current interRAI assessments completed by one of the five RNs who are interRAI trained. InterRAI assessments are used to inform the care plan.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The philosophy of care at CSNCC encompasses a planned approach to resident centred care. This is an area recognised as one of continuous improvement. Plans reviewed reflected an individualised approach that supports the needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the provision of care provided to residents at CSNCC was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a qualified diversional therapist with the assistance of twenty volunteers. A improvement initiative to expand the social opportunities and new events available to residents is recognised as an area of continuous improvement.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included 'move and groove' with the physio, visiting entertainers, quiz sessions, school and preschool visits, pet visits, van outings, church services, theme events, 'men's club' outings and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are consistently reviewed when short term problems arise (that is, infections, pain, weight loss), and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed.</p>

		Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Safe and appropriate waste management procedures including hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The laundry person demonstrated a good knowledge concerning waste and hazardous substances.</p> <p>Protective clothing and equipment including gloves, full face visor and disposable aprons were observed appropriate to recognised risks.</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 was displayed that expires on the 23 February 2019. The facility is well maintained both internally and externally. A preventive and a reactive maintenance programme is implemented and hot water temperatures are within the recommended range. Testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>There are areas throughout the facility for residents to frequent. The facility surrounds a court yard with gardens, lawns and outside furniture for residents to enjoy. Surfaces, both internal and external are flat. Residents were observed to easily manage with mobility aids.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All rooms are single and there is a mix of shared ensuites and rooms without ensuites. There are adequate showers and toilets located throughout the facility. Locking devices were observed for privacy.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Resident and families interviewed reported that there were sufficient toilets and showers and that they are easy to access.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of large and smaller bedrooms. Three rooms (2, 13 and 14) are available to accommodate residents assessed as requiring hospital or rest home level care (dual purpose). Bedrooms are large enough to provide personal space for residents, and allow staff and equipment to move around safely, including the bedrooms identified for the planned reconfiguration of services. Rest home rooms 4, 8, 9, and 10 for reconfiguration to dual purpose use are fit for this purpose.</p> <p>Rooms are appropriately furnished and maintained. Residents interviewed spoke positively about their accommodation. There is room to store mobility aids.</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>Residents have areas within the building to frequent, including dining and lounge areas that are easily accessed by residents. Residents can access areas for privacy if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and families interviewed reported there are adequate areas for them to access and enjoy.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>Personal laundry is washed and dried on site and all other laundry is carried out by an external contractor. Cleaning of the facility is completed by dedicated cleaners who demonstrated good knowledge including auditing of the cleaning and laundry processes. Review of audits confirmed this. Chemicals are stored</p>

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		securely. All chemicals were in appropriately labelled containers. The company representative visits monthly and provides on-going training for staff. Cleaning equipment and linen bags are colour coded for different uses.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The evacuation scheme was approved by the New Zealand Fire Service on the 2 February 2007. Fire drills are completed six-monthly, the most recent held on the 30 July 2018. There have been no building alterations since the previous audit. The emergency plan details emergency preparedness. Staff confirmed their awareness of emergency procedures. The orientation programme includes fire and security training. All required fire equipment has been checked and is current.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and a gas BBQ. A portable generator supplies emergency power. A call bell system alerts staff to residents who require assistance.</p> <p>The doors are locked in the evenings and external security lights are on overnight. Security cameras are situated at points around the court yard. Staff also complete security checks.</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>Heating is via panel heaters in all areas including individual heaters in the bedrooms. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All residents' rooms have natural light. The service has a smoke free policy that includes the external areas. Residents and families confirmed the facility is maintained at a comfortable temperature. During the audit, the temperature was appropriate in all areas.</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</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the FM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the FM is the designated infection control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to</p>

visitors. This shall be appropriate to the size and scope of the service.		<p>the FM and tabled at the staff meeting. Infection control statistics are entered in the organisation's electronic database and graphed to enable easy analysis.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse (ICN) has appropriate skills, knowledge and qualifications for the role. The ICN has undertaken training in infection prevention and control and attended relevant study days, within the last year. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory service is available if additional support/information is required. The ICN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICN and FM confirmed the availability of resources to support the programme and any outbreak of an infection.</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>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
Standard 3.4: Education	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing</p>

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.		<p>education sessions. Education is provided by suitably qualified RNs and the ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent influenza outbreak.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICN and FM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</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 minimisation and safe practice policy includes a definition, assessment and evaluation and complies with the requirements of the standard. The restraint coordinator, who is a RN was unavailable for interview. The FM reported the aim for Cook Street Nursing Care Centre is not to use any form of restraint. There were no residents using a restraint at the time of audit, and three residents using an enabler. Sensor mats, 'crash mats' and low-low beds are used so that restraint is not required. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	CI	<p>Although residents at CSNCC were receiving effective end of life care, it was recognised that it sometimes depended on the GP and the ability of staff to predict and recognise when to commence end of life care for the resident and their family including what time of the day, whether during the week with a lot of support around or after hours. This resulted in questions around how staff knew they were providing appropriate palliative care, how could it be measured and how could it be consistent for all residents in their care. Feedback received indicated families and residents wanted time to plan and to know what to expect when end of life came.</p> <p>The local hospice received funding to roll out a project across the MidCentral district called SEQUAL (Supportive Education and Quality Palliative Care). Cook Street Nursing Care Centre (CSNCC), with a focus on improving end of life care to residents, was selected as a pilot site to partner with Arohanui Hospice. The project aimed to empower CSNCC to ensure primary palliative care and the palliative approach to residential care is delivered, measurable and sustainable.</p> <p>The strategic goal of the SEQUAL project is to facilitate the vision: “All people with life limiting conditions live well and die well irrespective of their condition or care setting” within the aged residential care setting. A dedicated GP service for CSNCC has</p>	<p>The project has facilitated improved end of life outcomes for residents and their families with support from the local hospice and facility GP. Residents to date have not been required to be transferred to the DHB hospital. Family feedback has been very positive with reports that the enhanced approach to end of life care has made a difference in understanding the processes involved. Staff have a better understanding of the palliative approach to care and stated they are</p>

		<p>assisted in enabling this philosophy to be lived. The pilot site criteria was established as: facility philosophy that supports a palliative care approach; approved as suitable by the DHB; ARC management team supportive of SEQUAL proposal; FM in place for six months or more; able to identify a SEQUAL champion to be point of reference for SEQUAL communication; audit cycle three yearly +; any PA's low risk; and GP or NP keen to see the project succeed.</p> <p>The SEQUAL team completed a documentation review pre and post project. Post project showed improvement in all measurable areas of documentation. Showing anticipatory medications being charted, advance care plan discussions occurring, and no transfers to hospital for end of life (EOL) management. A palliative approach to care (PAC) has been incorporated in to documentation and includes quality targets. The PAC philosophy links with the Te Whare Tapa Whā philosophy.</p> <p>Evaluation of the project resulted in the end of life wishes documented in residents' files, 100% of anticipated deaths have an end of life care plan in place, anticipatory conversations take place in a supported environment with GP involved as required, anticipatory medications are charted for symptom management so the need for transfer to a DHB hospital is not required. A family survey was developed that is sent out three months post death. Surveys received showed very positive results indicating the changed approach to end of life care has made a difference. A staff survey by SEQUAL indicated gains in confidence with care and conversations. Strong working relationships have developed with the local hospice and the facility GP.</p>	<p>more confident with initiating end of life care and discussing this with residents and their families.</p>
<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>	CI	<p>The model of care at CSNCC is based on 'Te Whare Tapa Wha' and encompasses the cornerstones of care and humanity. It is stated that "The kindness and acceptance of meeting people where they are and building on this is the culture of CNSCC". Staffing levels are higher than those recommended by safe staffing guidelines, to ensure care staff have time to care.</p> <p>With a change in ownership of CSNCC, an initiative was implemented to revive the model of care and emphasise managements continual commitment to the model. Management has an open-door policy that enables any opportunity for improvement to be listened to, encouraged and implemented. Staff feel valued, staff turnover is low, and staff feel well supported, as evidenced by interviews and staff satisfaction surveys. Staff enjoy being at work and are enabled to care well. Physiotherapy services are provided, to enable residents increased strength and tone. A move to the facility's own GP (with residents' consent), enables GP services to be provided by a GP who is interested in</p>	<p>The philosophy of care at CSNCC is based around 'Te Whare Tapa Wha', allowing an individualised approach in the planning of care which encompasses all dimensions of wellbeing. This enables the residents to have the opportunity to regain function following admission and setbacks to their health improving quality of life and overall</p>

		<p>providing expert service that is responsive to the resident's needs.</p> <p>Evaluation evidenced resident wellbeing has improved. A number of residents have either improved to require a reduction in support needs or have been able to return home.</p> <p>Resident and family interviews provide evidence of improvement in resident wellbeing and overall improvement in quality of life, as a result of the care provided by CSNCC.</p> <p>Overall admission rates from CSNCC to the MCDHB have dropped.</p>	wellbeing.
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>To develop and create new events and social opportunities for the residents of CSNCC, the diversional therapist approached the local lions' group. The Lions ladies responded, and they met to discuss the concepts that could be developed to create a partnership that would benefit the residents of CSNCC and the Lions. Calendar events were initiated - Saint Patrick's Day, Queens Birthday, Daffodil Day and High Tea and there was a fashion show based round each of the themes. The Lions ladies participated as did the residents and families. The Lions then offered CSNCC the opportunity to support Breast Cancer awareness week. Five workshops were planned, encompassing Bra Art. The Lion's ladies assisted the residents to decorate the bras and entered them into the Palmerston North Bra Art competition at the local Home Show. All the communities Bra Art was on display and attracted a gold coin vote for the best Bra Art in each category. Money raised went to breast cancer. A resident of CSNCC was a prize winner. The Lions ladies continue to be involved with CSNCC. Any events planned are now in discussion and assistance with the Lions ladies for example, the yearly memory walk. Recently a baking day was held were the Lions ladies assisted the residents to bake cakes, which were then sold to raise funds for Lions. The Lions ladies have befriended the residents and pop in most days and get involved in CSNCC. They are involved in planning CSNCC events and participate or assist as required. It is a working partnership that is of benefit to all concerned. Volunteer numbers assisting in the service has increased from five to at times more than 20.</p>	<p>An initiative to expand the social opportunities, community involvement and events available to the residents of CSNCC has increased the volunteers involved in the service, improved the social networks between the service and the community and increased the diversity of the events accessible to the residents.</p>

End of the report.