# Henrikwest Management Limited - Craigweil House

## Introduction

This report records the results of a Partial Provisional 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:

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| **Legal entity:** | Henrikwest Management Limited |
| **Premises audited:** | Craigweil House |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | Start date: 19 December 2018 End date: 19 December 2018 |

**Proposed changes to current services (if any):** The proposed change is a reconfiguration of 14 rest home rooms for dual purpose use. Five of these fourteen rooms are to be reviewed for suitability as double occupancy hospital level services. This would effectively change the bed numbers to 20 Hospital beds, 9 rest homes, 20 dementia beds and 14 dual purpose beds. The total bed number would increase to 64-68 depending on outcome of the audit in respect to suitability of room size and ease of specialised equipment use.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 43

# 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.

## General overview of the audit

Craigweil House provides rest home, hospital and dementia level care for up to 68 residents. The service is operated by Henrikwest Management Limited and managed by a facility manager and clinical manager.

This partial provisional audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board. It included a review of the 14 rest home rooms intended for reconfiguration as dual purpose rooms (hospital and/or rest home services) and the suitability of five of these fourteen for provision of double occupancy hospital level services. The audit process included a review of policies and procedures, review of residents' and staff records, observations and interviews with management and staff.

There is one area identified as requiring improvement from this audit in relation to restraint minimisation and safe practice The other areas requiring improvement from the previous certification audit required for a partial provisional audit in service delivery have been addressed.

## Consumer rights

Not applicable to this audit.

## Organisational management

Business and quality and risk management plans include the scope, direction and objectives of the organisation. Monitoring of the services provided to the governing body is regular and effective. A suitably qualified person with experience in the sector manages the facility.

Appropriate employment processes are adhered to. Orientation is provided to all staff employed and an education and training programme has been developed and implemented. There is a roster that provides sufficient staff and appropriate cover for the effective delivery of care and support.

## Continuum of service delivery

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records are maintained electronically and include the documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

All food and baking is done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. The contracted dietitian has reviewed the menu plans. The service has a registered food control plan.

## Safe and appropriate environment

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

All bedrooms are currently single occupancy despite some rooms being designated shared rooms. There are adequate toilet and shower facilities. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of lounges and dining rooms throughout the facility and communal areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible and secure for the services that require this.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Appropriate training, information and equipment for responding to emergencies are provided.

## Restraint minimisation and safe practice

Not applicable to this audit.

## Infection prevention and control

The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is the facility manager who is responsible for coordinating and providing education and training for staff. An infection prevention and control committee is developed with representatives from across the services. The surveillance is used to determine infection control activities, resources and education needs within the facility. Staff receive ongoing infection control training.

## 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) |
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| **Standards** | 0 | 18 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 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) |
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| **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 |
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| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans are reviewed annually and outline the purpose, values, scope, directions and goals of the organisation. The documents describe annual and longer term objectives and the associated business plans.<br><br>The service is managed by a facility manager who holds relevant qualifications and experience in the aged care sector in management roles. The facility manager has been in the role since 12 November 2018. HealthCERT was notified of this appointment. The facility manager reports to the general manager. Responsibilities and accountabilities are clearly defined in a job description sighted. The facility manager is also a Careerforce assessor and has a current annual practising certificate which was reviewed. Relevant management education and ongoing training records were sighted which meet the requirements for this position.<br><br>The service holds contracts with the DHB for rest home level care, hospital and dementia care services. Forty three (43) residents were receiving services under the contract rest home level care (17), hospital (18) and dementia care service |

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| | | (8) at the time of audit.<br><br>The proposed reconfiguration will have no impact on the dementia service and/or the current designated hospital wing |
| Standard 1.2.2: Service Management<br>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the temporary absence of the newly employed facility manager, the clinical manager would carry out the duties of the facility manager. The clinical manager who has been in this role for approximately five months (since July 2018) would be supported by the general manager. There is an office manager and facility co-ordinator who both provide back up as required. Staff reported the current arrangements work well. |
| Standard 1.2.7: Human Resource Management<br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. The facility manager is responsible for this role. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. In the front of each staff record reviewed was a pre-employment checklist and competency records were able to be reviewed.<br><br>Staff orientation includes all necessary components to the role. Staff reported that the orientation process prepared them well for their role. The healthcare assistants interviewed also commented on the appointment of a team leader and this is working well. Staff records reviewed showed documentation of completed orientation that covers the essential components of service delivery and the services offered being rest home, hospital and dementia care. Job descriptions are provided for staff and responsibilities are outlined. Reporting systems are in place for staff to follow.<br><br>Ongoing education is planned on an annual basis and includes all mandatory training requirements. The Craigweil House in-service calendar for 2019 was sighted. The care staff have either completed or commenced a New Zealand Authority education programme to meet the requirements of the provider's agreement with the district health board (DHB). The majority of care staff have |

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| | | trained to level 4 on the NZ Qualifications framework. The staff employed in the dementia service have all completed the required training. The facility manager is a qualified assessor. There are currently nine registered nurses including the facility manager and the clinical manager. Two registered nurses are interRAI trained and are meeting the requirements to undertake interRAI assessments. The resident list recording assessments due was current and up-to-date. Annual performance appraisals were reviewed in the staff records sighted and showed these were up to date.<br><br>The facility currently provides hospital level care. The facility manager discussed the topics that are included in the annual training plan to support the provision of hospital level care. Qualified nurses have their annual competencies assessed by the clinical manager as recorded.<br><br>The current orientation and training programme reviewed was appropriate for the intended service reconfiguration and in particular if there is a further increase in hospital level residents in the facility. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mix to provide safe service delivery, 24 hours a day seven days a week (24/7). This is based on the indicators for safe aged care and dementia care.<br><br>The experienced facility manager employed 12 November 2018 oversees the staffing and adjusts staffing levels to meet the changing needs of residents. An afterhour on call roster is in place, with staff reporting that good access to advice is available when needed. The healthcare assistants reported there were adequate staff available to complete the work allocated to them. Observations and review of two fortnightly rosters confirmed adequate staff coverage had been provided with staff replaced in any unplanned absence. There is 24 hour/seven days a week RN coverage of the facility. The facility manager and the clinical manager both work 8.30 am to 4.30 pm Monday to Friday and are supported by the facility coordinator, operations manager and office manager who also work 9 am to 5 pm Monday to Friday. Casual staff are available if needed. The facility manager and the clinical manager provide registered nurse cover if and when required. On one occasion recently a Section 31 notice was completed as inadequate RN cover was available for a shift (an on-call arrangement was in place for the respective shift). Ongoing advertising and recruitment continues for registered nurses for this rural service. Currently there are nine registered nurses |

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| | | including the facility manager and the clinical manager. The contracted medical centre medical staff cover the facility after hours.<br><br>All management team interviewed stated that they were confident that staffing numbers would be increased as and when needed based on residents' needs if the dual purpose number of beds are increased. A recent increase in healthcare assistant allocation was noted with the appointment of the facility manager. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medicines management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.<br><br>A safe system for medicine management using an electronic system was observed on the day of the audit. The staff member observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manager.<br><br>Medications are supplied to the facility in accordance with requirements from the contracted pharmacy. The controlled drug register reviewed provided evidence of weekly and six monthly stock checks and accurate entries were recorded. The three lockable medication trollies are stored safely when not in use.<br><br>The records of temperatures for the medicine fridge were within the recommended range.<br><br>The GP is able to access the electronic medication system as needed and three monthly reviews are recorded on the electronic system when completed. Photo identification was on all medication records reviewed and dated appropriately. Allergies are recorded on the clinical records for individual residents and on the electronic medication record system.<br><br>No residents were self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed when required in a safe manner.<br><br>There is an implemented process for analysis of any medication errors.<br><br>The areas requiring improvement from the previous audit were reviewed and have been addressed. |

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| | | The current medicine system is suitable for the proposed reconfiguration. Registered nurses would be responsible for administration of the medicines for all hospital level residents. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by two cooks and kitchen hands and is in line with recognised nutritional guidelines for older people. The menu reviewed follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (letter dated December 2017). The main cook has worked at the facility since March 2018. A relief cook covers two days a week. The kitchen hand interviewed had been employed for two months at this facility. Full orientation was provided for this role.<br><br>All food stuffs are ordered by the facility coordinator. The cook checks all orders when delivered to the facility and ensures the fridges and freezers temperatures are completed and recorded daily. The service operates with a current and approved food safety plan issued by the Auckland City Council. The required information is displayed in the kitchen. The kitchen staff have completed relevant food handling training. The cook is responsible for the preparation, storage, transportation and disposal of food in line with current legislation and guidelines. All food stuffs were labelled and dated and the staff were seen wearing personal protective equipment.<br><br>The registered nurses complete a nutritional assessment for each resident on admission to the facility and a dietary profile is developed. A copy is given to the cook and a copy is retained in the individual resident's record. Any personal food references, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. These are documented on the white board sighted in the kitchen. Special equipment to meet resident's nutritional needs is available.<br><br>Food is available 24/7 for residents with dementia.<br><br>Evidence of resident satisfaction was able to be verified by resident and family interviewed. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. The portion sizes and food presentation was observed at lunchtime and was appropriate. Fresh produce was sighted in the cooler. The cook interviewed verified that full cream milk powder is used for baking, cooking and in beverages as needed. Soya milk is also available. Cream is used for desserts and for baking. Processes are now in place |

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| | | to monitor any residents who have been identified as having a significant weight loss. The clinical manager interviewed ensures the process is followed appropriately. The resident is referred to a general practitioner and a short term care plan is developed and implemented. The service contracted dietitian is also involved in the planning of care.<br><br>The current food service is suitable to manage the proposed reconfiguration changes. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has included interRAI assessment protocols within its current documentation. The admission assessment and care plans were completed for all the resident records reviewed. The interRAI assessments are used to inform the care planning process. InterRAI initial assessments and assessment summaries were evident in printed format in all records reviewed. There are two registered nurses who are fully competent to perform the interRAI assessments.<br><br>Records reviewed across the services identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional risk assessments for care planning and interventions, and staff training occurring as part of the programme for preventing pressure injuries was reviewed. Appropriate policies and procedures are available to guide staff. Management of behaviour, wound care, pain and nutrition were completed according to need. For the resident records reviewed, formal assessments and risk assessments were in place and were reflected into care plans. This was an area identified for improvement in the previous audit and has been effectively addressed. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Staff interviewed reported that the needs of residents in all service areas are being met. The appointment of a team leader for the healthcare assistants has been successful and the staff member acting in this role is reported by staff to be respected. Support is provided by the registered nurses and the clinical manager. Continence and wound care products are readily available and short term care plans are implemented as required. The continence and wound care products are ordered by the facility coordinator with registered nurse input.<br><br>Written progress is documented to assist review and evaluation of any wounds. The required interventions were documented on the respective care plans |

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| | | reviewed and evaluated to ensure goals can be met.<br><br>Monitoring records were in use and were sighted including for weight, vital signs, blood glucose levels, pain, food and fluid and behaviour monitoring as required.<br><br>This was an area of improvement identified in the previous audit which has now been addressed. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed had been evaluated by the registered nurses' six monthly or earlier if required. New care planning templates have been introduced. As care plans are reviewed the new templates will be implemented. There was a multidisciplinary review documented in the residents' records reviewed. The multidisciplinary review involves the RN, GP, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and talk to the GP as arranged.<br><br>Written evaluations described each resident's progress against the set goals. InterRAI assessments have been utilised in conjunction with the six monthly reviews. Short term care plans for short term needs were evaluated and either resolved or added to the long term care plan as an ongoing problem.<br><br>This was an area of improvement identified in the previous audit which has now been addressed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant education and training for staff. Material safety sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.<br><br>There is provision and availability of protective clothing and equipment and staff were observed using this. The facility coordinator interviewed is responsible for ordering and ensuring adequate supplies are on site at all times.<br><br>No changes will be required to accommodate the intended reconfiguration. |

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| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is publicly displayed with an expiry date of 8 February 2019. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for the purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current in documentation reviewed, and confirmed in interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.<br><br>External areas are safely maintained and are appropriate to the resident groups and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents reported they were happy with the environment. The residents in the dementia service are able to move freely outside and around the grounds and re-enter the facility. Pathways have even surfaces.<br><br>No changes will be required to accommodate the intended reconfiguration. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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. | FA | There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The dementia service has separate bathrooms. The rest home has bathrooms in close proximity to the individual rooms. In the hospital wing the bathrooms are shared between two rooms. There are three ensuite bathrooms only in the hospital wing. Visitor and staff toilets are available. All showers are in working order. Hot water temperatures were monitored regularly. A facility maintenance programme is in place.<br><br>No changes will be required for the intended reconfiguration. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The current service has 63 rooms. Five of these in the rest home section are dual occupancy or double rest home bedrooms.<br><br>The service intends and is seeking approval to reconfigure 14 rest home level beds for dual purpose beds. The rooms involved R1a, R1, R2, R5, R6, R8, R9, R10, R17, R18, R19, R20, R21 and R22. All rooms sighted are suitable for dual purpose beds. Two rooms room 17 and 19 have been changed since the |

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| | | previous audit and now have double door access to these rooms and a single free standing wardrobe in each room instead of a double wardrobe, which provides more space in the rooms. There is a chair at the far end of each room away from the external doorway. A hoist can now be used if required in these two rooms (eg, for a hospital level resident). This was discussed with the facility manager who stated that these two rooms would be used in consideration of patients' needs and equipment requirements for eg; end of life palliative care residents only.<br><br>Of the 14 rest home bedrooms considered R1a, R5, R6, R8, and R9 are currently designated double rest home bedrooms. However, there is only one resident presently occupying each room. R1A, R5 and R6 are the only rooms suitable for hospital level double rooms. The other two rooms are not large enough to accommodate two beds and/or additional equipment required for hospital level residents. If rooms are to be shared, approval will be sought. These individual rooms could be designated swing beds but for single hospital, not double hospital. The individual resident's rooms in the hospital wing are about the same size but have the ensuite bathroom between two rooms.<br><br>Occupied rooms on visual inspection are personalised with furnishings, photos and other personal items displayed. A lighting issue raised in the previous audit has been addressed in the interim time. All rooms have a centre light, but not a nightlight or bedside light. One resident requiring more light has had an LED light installed which is battery operated to provide more light. A plan to increase lighting in the rest home and other areas has been assessed for feasibility improvements by the preferred electrical company and the service provider is awaiting the outcome.<br><br>The proposed reconfiguration will have no impact on the dementia service or the designated hospital wing.<br><br>There is room outside of the rooms in recessed areas to store wheel chairs and mobility scooters. The staff supported adequacy in respect to the size of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age | FA | Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. New furniture has been |

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| appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | | purchased which is appropriate to the setting and residents' needs.<br><br>No changes will be required to accommodate the intended reconfiguration. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry and processes, dirty/clean flow and handling of any soiled linen. The family and residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Staff receive training. Chemicals were stored in a locked cupboard and were in appropriately labelled containers. The trollies are stored in a locked cupboard when not in use. Cleaning and laundry processes are monitored through the internal audit programme. The facility coordinator is responsible for the ordering of supplies for both the cleaning and laundry services from the preferred providers of choice. The facility was clean and was odour free.<br><br>No change will be required to accommodate the intended reconfiguration. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies, procedures and guidelines for emergency planning preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for any disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service, the most recent reviewed was dated the 29 September 2016. Trial evacuations occur six monthly. Fire safety is covered in the orientation programme for new staff. Staff confirmed their awareness of the emergency procedures. The needs of residents with dementia have been considered in relation to evacuation processes.<br><br>Adequate supplies for use in the event of a civil defence emergency including food, water (have access to a bore), blankets, mobile phones and gas barbecues were available and meet the requirements for the 43 current residents. Emergency lighting is regularly tested.<br><br>Call bells alert staff to residents requiring assistance. Staff responded promptly to call bells.<br><br>A newly installed security system is in place. Video surveillance cameras are located around the facilities and families/residents have been informed. The screen is accessible. Staff are also responsible for security checks and rounds |

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| | | are documented in the communication book.<br>No change will be required with the intended reconfiguration. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and an open external window. The dementia service, rest home and hospital wing are maintained at a comfortable temperature.<br>No change will be required in relation to the intended reconfiguration. |
| Standard 3.1: Infection control management<br>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Craigweil House has an implemented infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual. The manual was reviewed January 2018. The infection control programme and manual are reviewed annually.<br>The infection control coordinator is currently the facility manager whose role and responsibilities are defined in a job description. The infection control committee consists of the facility manager, the clinical manager, facility coordinator, team leader, domestic and laundry staff members. Surveillance results are reported monthly and tabled at the quality and risk meeting. The general manager is notified of any results or infection control issues.<br>Visitors are encouraged not to enter the facility if they have been unwell in the past 48 hours. Staff are also well informed of when they should not come to work if unwell and when to return. Staff interviewed understood these responsibilities. |
| Standard 2.2.3: Safe Restraint Use<br>Services use restraint safely | PA Low | Approved restraint is only used as a last resort to maintain the safety of consumers, service providers and others. A corrective action report from the previous audit was currently being followed up with the DHB but was reviewed to assess progress against this standard and as part of this partial provisional audit for a configuration of beds to dual purpose. There were no residents in the dementia service using a restraint however, there is an ability to lock bedrooms in the dementia unit. No rooms were locked in visual inspection during this audit. Annual restraint training is planned for 2019 as per the training schedule sighted |

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| | | and verified at interview with the facility manager. Monitoring of restraint use has improved and ongoing monitoring of this process occurs. The clinical manager and the registered nurses are responsible for overseeing the monitoring process. The monitoring forms are signed off at the end of all shifts by the RN. A restraint register is available and maintained. |

# 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) |
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| Criterion 2.2.3.2<br>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:<br>(a) Only as a last resort to maintain the safety of consumers, service providers or others;<br>(b) Following appropriate planning and preparation;<br>(c) By the most appropriate health professional;<br>(d) When the environment is appropriate and safe for successful initiation; | PA Low | The facility manager was interviewed and discussed the area for improvement identified in the previous audit. Education is provided to staff at the staff meetings. Restraint monitoring education has occurred as part of the in-service programme December 2018 but not all staff have completed this training. This will be repeated for 2019 as part of the annual restraint minimisation and safe practice education. The facility manager stated there has been an improvement in completion of monitoring forms and this is being overseen by the RNs each shift. There is still provision for doors to be locked in the dementia service with locks in place. This is an area of improvement which is still ongoing. | Not all staff have received the required education for restraint minimisation and safe practice. There is still an ability to lock bedrooms of residents in the dementia service. | Further education is required for all staff on restraint minimisation and safe practice. Ensure residents can freely access their own rooms at any time.<br><br>30 days |

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| (e) When adequate resources are assembled to ensure safe initiation. | | | | |

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

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

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

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

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End of the report.