

Tamahere Eventide Home Trust - Atawhai Assisi Home and Hospital

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:

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| Legal entity: | Tamahere Eventide Home Trust |
| Premises audited: | Atawhai Assisi Home and Hospital |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 24 January 2019 End date: 25 January 2019 |
| Proposed changes to current services (if any): | Adding Hospital services – Medical services |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 81 |

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 |
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|  | 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 |
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| | 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

Atawhai Assisi Home and hospital provides rest home, hospital geriatric and hospital medical care to a maximum capacity of 86 residents. The provider meets the requirements for these types of service. This planned certification audit against the Health and Disability Services Standards and the provider's contract with Waikato District Health Board (WDHB) was the first audit conducted since the service was purchased by Tamahere Eventide Trust in April 2018.

The audit process included the review of policies and procedures, review of residents' and staff files, observations, interviews with residents and their families, managers, staff and the contracted general practitioner.

This audit did not identify any areas requiring improvement and confirmed that the issues identified at the provisional audit prior to purchase have been fully resolved. Three continuous improvement ratings were confirmed in relation to food, consumer information management and a quality initiative to reduce falls and minimise staff injuries. Implementation of new strategies in these three areas has resulted in improved services and increased safety and satisfaction for residents and staff.

Consumer rights

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| 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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Atawhai Assisi Home and Hospital residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. The services provided support personal privacy, independence, individuality and dignity. Residents confirmed staff interact in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

The complaints management system meets the requirements of the Code and is known by staff, residents and their families. There have been no serious complaint investigations since the new provider takeover. Families reported that staff immediately respond to and begin to address any concerns they raise.

Organisational management

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| 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. |
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The Trust Board provides effective governance. The board meets monthly and are kept informed about all aspects of the organisation. The chief executive officer (CEO) and the two other members of the senior management team are appropriately qualified for their positions and/or are experienced with working in the aged care sector.

There are well established quality and risk management systems which meet these standards. The organisation continues to benchmark its quality data against similar age care services. Risk management systems are fully implemented. All adverse events were being reliably reported and investigated. None of these have required notification to the district health board and the Ministry of Health.

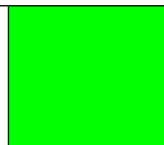
Staff are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff and has been strengthened by the new clinical nurse educator. Ongoing staff education is planned and delivered in ways that ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Staff attendance at mandatory education sessions is monitored. The training is available to all staff through in-service teaching sessions, self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals are occurring regularly.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week exceeds contractual requirements.

Consumer information management systems meet the required standards.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed (hard copy and electronic) demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

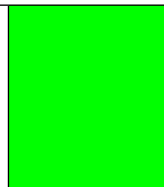
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

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

Safe and appropriate environment

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



Standards applicable to this service fully attained.

There are safe and effective methods for managing waste and hazardous materials.


The building has a current warrant of fitness. Electrical equipment is being tested and tagged by a registered electrician. All medical equipment is serviced and calibrated annually. Hot water temperatures are monitored.

All the bedrooms are for use by a single occupant. The majority of hospital rooms have attached bathrooms. The rest home bedrooms are located within easy walking distance to ablutions and communal areas. The furniture fittings, and building layout are appropriate to the needs of older people. External areas have been improved upon to ensure they are safe and appealing and are being well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Regular monitoring and reporting on the outputs from cleaning and laundry services contributes to good standards in these areas.

Emergency systems and the equipment needed for emergencies, including the ability to provide sufficient food and water for the number of residents for at least three days, is being checked frequently. There is an approved evacuation scheme and systems for ensuring that all staff can safely manage fire and emergency situations. There is always a staff member with current first aid certificate on site.

Residents' bedrooms and communal areas are heated in ways that provide comfortable and constant internal temperatures

Restraint minimisation and safe practice

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| 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 policy and procedures comply with this standard and are written in a way that clearly guide staff. On the days of audit there were seven restraint interventions in place and one resident using a bedrail as an enabler. The need for these had been appropriately assessed and consent obtained. Staff knowledge about the organisation's approach to restraint and their competence in safe application of restraint interventions is tested at least annually.

Infection prevention and control

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| <p>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.</p> | | <p>Standards applicable to this service fully attained.</p> |
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, 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) |
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| Standards | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 3 | 98 | 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Consumers' Rights (the Code). New residents and families are provided with a copy of the Code on admission and this is included in the information pack.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents' rights and their implementation. Education regarding consumer rights is held as part of the education calendar. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights in a manner that was individual to the resident's needs.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form and this was evident in the</p> |

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| | | residents' files reviewed. Where a resident is deemed incompetent to make an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care. |
| <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 and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The registered nurse provided examples of when the involvement of Advocacy Services would be encouraged or utilised.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome and included 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 complaint management system complies with right 10 of the Code and the requirements of this standard. Review of the electronic complaints register and interview with the Chief Executive Officer (CEO) confirmed there have been seven complaints received since April 2018. None of these were received by the Office of the Health and Disability Commissioner. The records showed that each complaint has been resolved to the satisfaction of the complainant.</p> <p>All concerns, complaints or compliments are entered into the software system as soon as they are received. Details about the matter and its progress is then accessible to the CEO and authorised senior staff. Significant matters are discussed at monthly senior management meetings and reported to the board. Staff, residents and their family members interviewed demonstrated knowledge and understanding of the complaint process. Families described staff as being open, responsive and keen to address any matters they raised with them.</p> |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admissions agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff.</p> |
| <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> | <p>FA</p> | <p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit with observed interactions.</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> | <p>FA</p> | <p>The General Manager Care Services, registered nurses and caregivers interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents who specifically identified with their culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture and a Maori health plan was available. There are clearly described policies and procedures related to care of Maori residents which are available to staff. Staff education in cultural sensitivity is ongoing.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's</p> | <p>FA</p> | <p>The spiritual, religious and cultural policy documents that the admission</p> |

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| <p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | | <p>process includes assessing specific cultural, religious and spiritual beliefs. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate and chaplains are on site most days.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture and enjoy the activities that are organised within the facility and within the community.</p> |
| <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. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</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, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons. A general practitioner who provides services was interviewed and confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Other examples of good practice noticed were the staff knocking on residents' doors before entering and the observation of staff encouraging and supporting residents to make day to day decisions. Family interviewed stated that they always felt welcomed by staff and included in the activities occurring at the time.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents'</p> |

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| | | <p>records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff have adapted to support residents who struggle with verbal communication and vision impairment and use simple phrases, clear direction, gestures and a tablet that the resident can easily respond to. Interpreter services are available if needed or family are invited to assist with communication.</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> | <p>FA</p> | <p>Tamahere Eventide Trust who govern Atawhai Assisi have agreements with WDHB to provide age residential care for hospital geriatric and rest home services, respite/short term and end of life care, services to people under 65 years with long term chronic health conditions and a day activities programme.</p> <p>Atawhai Assisi has a total capacity of 86 beds available, 46 of which are designated for hospital level care and 40 for rest home care. There are eighteen rooms designated as dual purpose (that is, approved for either hospital or rest home care), but the care services manager stated that in there are only ever five hospital rooms that would ever be used for rest home residents. The hospital and rest home areas are distinctly separated at either end of the building.</p> <p>On the first day of audit there were 81 residents on site. Of these, 38 residents (including one person on planned respite) were receiving rest home level care and 43 hospital level care.</p> <p>The organisation has a clearly described scope, direction and goals documented in its three year Strategic and Business Plan. The CEO, General Manager (GM) Care Services, and GM Support Services report progress against the goals related to their service areas to the board every month.</p> <p>A new board member was appointed to represent Atawhai Assisi last year. The board meet monthly with the CEO to consider all operational and financial business. Review of the reports to the board showed they are provided current information on occupancy rates, health and safety matters, audit outcomes, staffing information, financial reports, information about complaints and compliments received, resident care,</p> |

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| | | <p>quality and other service delivery matters.</p> <p>The CEO who has been in the role for 21 years, has extensive experience as a manager in the health sector and is qualified in business management and leadership. The GM Care Services is a registered nurse with extensive clinical and managerial experience in aged care. The GM Support Services who is the appointed Health and Safety Officer, was a previous Trustee and has long term experience with building and project management. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.</p> |
| <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>The senior management team split their time on site at Atawhai Assisi according to work demands, with time spent at Tamahere Eventide the other nearby age care facility they have overall responsibility for. Each of the managers reported they have been able to incorporate the extra workload through the appointment of clinical nurse leaders at both sites and delegated authority to team leaders. Discussions with the CEO, senior management and other staff confirmed that temporary cover during the CEO's planned absences is delegated to the GM Care Services or the GM Support Services. The Clinical Nurse Leaders (CNLs) cover when the GM Care Services is absent. Staff stated these arrangements were proven to be effective and ensured continuity for staff, residents and their families.</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 quality and risk management system is integrated with all areas of service delivery. Policies and procedures are now integrated across the two facilities governed by the trust. Staff interview confirmed the transfer to a new set of forms and policies was managed well. The policy set in use is industry standardized by an external consultant and all are controlled and reviewed at least two yearly or when changes are indicated. Changes require authorisation at senior management level. A pre audit documentation review revealed that policies were current.</p> <p>Quality and risk matters are reported and discussed at a range of staff meetings. Review of meeting minutes reveals that resident care including their adverse events, health status, infections and behavioural concerns are discussed at RN meetings, hospital and rest home staff</p> |

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| | <p>meetings. Senior managers review incidents/accidents, complaints, staffing, financial and project matters at their meetings and the health and safety committee consider staff injuries and the impact of environmental issues on services.</p> <p>Internal audits (for example, of care records, safe medicine administration, food and environment) are being conducted by the GMs, CNLs, or members of the hospitality and maintenance services team who monitor their areas of service delivery. Where audits, incidents, complaints or feedback identify deficits, these are reported verbally and in writing. A range of corrective actions are discussed with relevant people and the most suitable actions are implemented. The organisation presents staff with quality awards to recognise individual initiatives or when they perform to a level above what is expected in their role.</p> <p>Atawhai Assisi are now participating in the 'QPS' benchmarking programme and comparing 26 indicators with similar aged care facilities across Australia and New Zealand. This information is analysed by the senior management team to identify trends and is reported quarterly to the trust board.</p> <p>Risk management processes are integrated with the quality monitoring system. The business risk management plan includes service provision, human resources, natural disaster planning, health and safety, contractual compliance and financial risks. The health and safety committee report all matters that require communication and discussion at staff and management meetings. Environmental checks to assess for health and safety are conducted regularly and reactive facility maintenance occurs. The hazard register is being updated as new hazards are identified. Chemical safety data sheets which provide information about hazardous chemicals are displayed in various locations on site. All accident / incident reports are considered by a multidisciplinary team as a means of identifying and preventing avoidable risks. Health and safety and essential emergency processes are mandatory topics during orientation and as part of the annual staff education plan. The interRAI assessment process identifies each resident's clinical risks and service delivery plans described how these will be mitigated.</p> <p>There is a rating of continuous improvement in criterion 1.2.9 for the</p> |
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| | | successful outcome of a project to reduce staff and resident injuries. |
| <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>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated quarterly by the CEO and other senior managers. Avoidable events are evaluated, and actions are implemented to prevent recurrence (refer to standard 1.2.9 for quality improvement to reduce staff and resident injuries).</p> <p>Interviews and review of incident data on the days of audit confirmed that incidents are discussed at shift handover, and trending data is displayed in the staff room. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The CEO is responsible for essential notifications and reporting and understands the statutory and regulatory obligations. There have been no incidents requiring notification to the DHB or Ministry of Health since takeover in April 2018. The appointment of a new board member was notified.</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>Staff management policies and processes 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 sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. The orientation programme has been reviewed and updated to ensure all new staff have one to one time with the clinical nurse educator (CNE) before starting work and then return for a mandatory orientation day which occurs monthly. New staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review after 90 days.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. All care staff are expected to</p> |

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| | | <p>commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment, if they do not already have qualifications. The CNE is an authorised moderator of the education programme provided on site. Each of the staff files reviewed contained evidence of annual performance appraisals.</p> <p>Seven RNs are maintaining annual competency requirements to undertake interRAI assessments. Another is in the process of interRAI training.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>This standard required improvement at the previous provisional audit in March 2018. Observations and review of the rosters and interviews with management and care staff revealed this is no longer the case. There are more than the required numbers of staff allocated (as per the ARC contract) on each shift in the rest home and hospital wings.</p> <p>A full time clinical nurse leader (CNL) oversees the care being delivered to rest home residents Monday to Friday, along with another CNL who oversees hospital level care.</p> <p>The rest home roster has four caregivers for the morning and afternoon shift (plus the CNL and an EN or RN) and an RN and caregiver at night. The hospital wing has 10 caregivers for the morning shift and eight in the afternoon (plus the CNL and two more RNs) with three caregivers and one RN at night.</p> <p>The organisation implemented significant change to the previous methods of rostering. All care staff now work four days on and two days off and are employed for guaranteed minimum hours of 31.5 hours for caregivers and 37.3 hrs for RNs per week. A total of 13 RNs and two enrolled nurses allows for four RNs (plus the CNLs) to be on site for all morning and afternoon shifts and an RN on call after hours. There are two RNs on site at night and at least six staff members with a current first aid certificate on duty at all times.</p> <p>The care staff interviewed said there were sufficient numbers of staff, for the needs of the residents, allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. Reports showed agency staff usage has decreased.</p> <p>The service employs an appropriate number of dedicated auxiliary staff</p> |

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| | | (for example, activities, rehabilitation, cooks, cleaners, management, administration and maintenance staff) for the size and scope of the service. Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided. |
| <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>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The latest archived records are held securely on site and are readily retrievable using a cataloguing system. The administrator interviewed stated that the organisation holds older records off site and in a secure building not able to be viewed at the time of audit.</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. The provider has implemented an electronic client management system since acquiring the facility. Both the electronic records and the holding hard copy file were reviewed. 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 provider notes. This includes interRAI assessment information entered into Momentum electronic database. The records (hard copy) not yet fully integrated into the new electronic system were legible with the name and designation of the person making the entry identifiable. The electronic records clearly identified the person and designation of those making an event note.</p> <p>Atawhai Assisi has now transitioned to a fully electronic consumer information management system, so resident records are fully integrated and management staff can access records off site. Staff have access to records at security levels appropriate to their role. This has resulted in improvements which are described in criterion 1.2.9.1</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p> | FA | <p>Residents enter the service when the required level of care has been assessed and confirmed by the local Disability Support Link (DSL) provider. Potential residents and/or their families are encouraged to visit</p> |

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| <p>equitable, timely, and respectful manner, when their need for services has been identified.</p> | | <p>the facility prior to admission and are 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.</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> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service uses the DHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the electronic system. There was evidence in the holding file (hard copy information not in electronic system) of the use of the 'yellow envelope' when a resident was transferred to the acute care facility with supporting documentation and evidence of communication between the facilities and the family. Families reported being kept well informed during any transfer of their family member when this occurs.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The medication management policy is current and identifies all aspects of medication management in line with the Medicine Care Guide for Residential Aged Care. A safe system for medicine management was observed on the day of audit. An electronic system has been invested in since change of ownership. The staff observed demonstrated good knowledge and 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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks against the prescription. All medications sighted were within the current use by dates. Clinical pharmacist input is provided if required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The record of temperatures for the medicine fridge and medication room reviewed were within the</p> |

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| | | <p>recommended range. Commencement and discontinuation and all pro re nata (PRN) medicines followed good prescribing and management practices. The required three-monthly GP reviews were consistently recorded. No residents were self-administering medicines at the time of audit. Staff were able to describe process, documentation used and what was in place to support, safe storage, in the rooms should it be required.</p> <p>There is a clear process for reporting and analysing any medication errors.</p> <p>Staff and the GP reported the benefits gained through the introduction of the new electronic system. Staff reported increased confidence and accuracy.</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 kitchen team consisting of two chefs and two kitchen hands who are well supported by the facility management structure. The food service is delivered in line with recognised nutritional guidelines for older people. The menu follows a summer and winter cycle and the menu rotates on a six weekly schedule. The menu has been reviewed by a qualified dietician. Any recommendations are followed and changes made as necessary.</p> <p>All aspects of food procurement, production, storage, transportation, delivery and disposal comply with current legislation and guidelines. The food safety plan has been submitted and copy of this was on site. Food temperatures, including for high risk items, are monitored and recorded appropriately. The kitchen team leader 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 personal food preferences, any special diets and modified textures are made known to the kitchen staff and accommodated in the daily meal plan.</p> <p>A continuous improvement is described in criterion 1.3.13.2 related to the introduction of a new system for providing modified food.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> | FA | <p>If a referral is received but the prospective resident either does not meet the required criteria for entry or there is no vacancy, the local Disability</p> |

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| <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | | <p>Support Link is advised to enable the family and resident to be supported to find an appropriate alternative. One resident has been declined to date due to the facility not having access to specialised equipment at the time of referral.</p> <p>If there is change in service need, a referral is generated to DSL for reassessment with a request to locate a new placement to meet the needs of the resident. This referral is made in consultation with the resident and their family/ whanau. There is a clause relating to this on the access agreement which clearly stipulates when a resident placement may be ceased.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>Information is documented using validated nursing assessment tools, such as a falls risk, pain scale, skin integrity, behaviours that challenge, nutritional screening and depression scale, to identify any deficits and to inform care planning when the residents is first admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents had up to date interRAI assessment. Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>FA</p> | <p>Residents' care plans reviewed reflected their support needs and the assessment process and other relevant clinical information. This included behaviour management plans including triggers and interventions for behaviours, and the support required to encourage residents to participate and to be part of the community. This was integrated throughout the long term care plan. The needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>There was evidence of service integration throughout the care plans, with progress reports, activities notes, and rehabilitation therapist notes, medical and allied health notations in both the electronic and the holding file (hard copy). These were informative and relevant and reflected the goals identified. 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</p> | <p>FA</p> | <p>Documentation, observations and interviews verified the provision of care was consistent with residents' needs, goals and the plan of care.</p> |

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| <p>meet their assessed needs and desired outcomes.</p> | | <p>There was evidence of the staff meeting the residents' individualised needs. The GP interviewed, verified medical input was sought in a timely manner, medical orders were followed and the care was of a high standard. The GP made particular reference to the introduction of the electronic system adding value and increasing confidence for all involved. Care staff, the clinical lead and the resident/families confirmed that care was provided as outlined in the care plans. A range of equipment and resources were available including the introduction of new ceiling hoists. (Refer 1.2.3.9) These are all suited to the levels of care provided and in accordance with the resident's needs.</p> |
| <p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activities programme is provided by three trained diversional therapists holding the national Certificate in Diversional Therapy, and the day programme co-ordinator. The rehabilitation therapist also compliments a comprehensive activities programme. One of the diversional therapists is a facilitator for the Spark of Life Programme. The activities staff support residents Monday to Friday from 9am to 4.00pm.</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 activities programme that is individualised and meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six monthly integrated care plan review.</p> <p>Activities reflected resident's goals, resident's natural rhythms and patterns of life including their involvement in normal community activities and events. Individual, group activities and regular events are offered. The team have developed within the facility different clubs (eg, café club, poetry and choir), for residents to belong to. Residents and families are involved in evaluating and improving the programme through residents' meetings and residents' surveys. The chaplain chairs the meetings. Care staff are encouraged to participate via inputting to the types of activities being offered. Residents interviewed confirmed they find the programme "excellent" and the clubs "fun". Several interviewed made specific reference to the café club and the use of china cups.</p> <p>At the time of interview, the staff presented an initiative where they introduced "individualised resident personal packs". Each pack</p> |

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| | | <p>contained cultural, spiritual and past artefacts important to the individual which were part of the reminiscing techniques the staff used to engage residents. For those who did not have a pack the staff were making individualised sensory cushions. A sample of these were presented at the audit. Families and residents had input into what was contained in the packs or what was presented on the cushions.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Residents' care is evaluated on each shift and reported in progress notes. If any change is noted, it is reported to the registered nurse. Formal care plan evaluations occur every six months in conjunction with interRAI reassessments, or as residents' needs change. All evaluations were up to date at the time of audit. Where progress is not as anticipated, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed confirmed their involvement in evaluation of progress and any resulting changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and /or disability service providers. Although the service has a facility doctor and a nurse practitioner, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, nurse practitioner or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' files as well as integrated note writing on the electronic system. These included physiotherapy, hospice services and clinical nurse specialists. The resident and family are kept informed of the referral process, as verified by documentation, event notes (electronic system) and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. The facility has also introduced the 'Situation, Background, Assessment, and Recommendation' Tool ('SBAR') which the GP has confirmed has improved consistency and quality of information provided.</p> |

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| <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> | <p>FA</p> | <p>All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage chemicals and cleaning products and provide staff with product information. No adverse events related to chemicals have occurred. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A significant water and waste issue under the kitchen has been identified and remediated. Appropriate signage is displayed where necessary.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness expiring on 18 April 2019 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists, electric beds and medical equipment occurs annually. The testing and tagging of electrical equipment is carried out annually by an external contractor. Maintenance staff conduct weekly checks of equipment (hoists, walkers and wheelchairs) and carry out minor repair work. There is a preventative maintenance schedule which is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said requests are actioned in a timely manner. This was confirmed by review of the maintenance request register.</p> <p>The internal environment is hazard free, residents are safe and independence is promoted. Communal living space in the rest home wing has increased with the demolition of a conservatory and new external walls installed which has not affected the approved evacuation scheme. External areas have been cleaned, insect protected and enhanced for residents' use. All inside and outside areas are being maintained as safe and fit for use.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> | <p>FA</p> | <p>There are sufficient numbers of accessible bathroom and toilet facilities</p> |

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| <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> | | <p>throughout the facility. This includes forty of the 45 bedrooms in the hospital with either shared or individual ensuite bathrooms. Three bed baths are also in use. The toilet and shower facilities for rest home residents are shared, with a minimum of three bathrooms and one toilet for ten residents. There are sufficient additional toilets located throughout the building and adjacent to common areas. All bathrooms and toilets have functional locking systems for privacy. Staff and visitors' toilets are separately designated and additional staff toilets have been installed by the new provider. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All ablution areas are in good condition. The testing and monitoring of hot water temperatures occurs monthly. Records showed a history of temperatures being below 45 degrees Celsius.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>All bedrooms have a single occupant. Attention is paid to the layout of furniture in bedrooms to allow residents and staff to move around safely. Designated rest home only bedrooms are older and limited in size which restricts the positioning of their beds and the amount of personal items and furnishings that residents can bring in. Some of the newer hospital bedrooms with private ensuite bathrooms attract additional premium charges to the occupier.</p> <p>There is sufficient space in corridors and most rooms to store mobility aids and wheel chairs. As reported in criterion 1.2.3.9 ceiling hoists have been installed in 16 hospital rooms. This has greatly enhanced resident and staff safety. Residents and family expressed satisfaction with the bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>A number of communal areas are available throughout the facility for residents to engage in recreation, visiting or dining. There are three separate dining areas; two in the rest home and one in the hospital wing. A large activity meeting room and separate physiotherapy gym are located centrally and are easily accessible for all residents. There are additional lounges in each wing for quiet time, privacy or visitors when required. A whanau room is available for family who are supporting unwell residents.</p> <p>Furniture is in good condition and appropriate for the people who live</p> |

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| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Designated cleaning and laundry staff are on site seven days a week. These staff have achieved qualifications in safe handling of chemicals and are provided with ongoing health and safety education from the health and safety officer. This was confirmed in interview with staff and review of their personnel records.</p> <p>Staff follow established routines for cleaning and all areas are maintained as hygienic. Site inspection revealed no concerns with cleaning. Chemicals are stored securely and are decanted into clearly labelled containers.</p> <p>All the laundry is being managed on site according to known protocols for dirty/clean flow and the handling of soiled linen. Improvements have been made to soak basins, storage bins and by moving an extra washing machine into the laundry There have been no concerns expressed from staff, resident or relatives about cleaning or laundry services since the new ownership.</p> <p>Cleaning and laundry processes are routinely being monitored for effectiveness via the internal audit programme, from the external cleaning product supplier and through resident/family surveys and feedback.</p> |
| <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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan has been approved by the New Zealand Fire Service. Trial evacuation drills are occurring every six months, and all staff are attended fire and emergency updates annually. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (86). Potable water is stored in the building, plus 35,000 litre capacity water tanks are on site. Apart from a backup battery for lighting (which is regularly tested) there are no generators on site for power</p> |

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| | | <p>outages. The protocol is to hire one.</p> <p>Call bells alert staff to residents requiring assistance. Staff were observed to respond within reasonable timeframes to these.</p> <p>Appropriate security arrangements are in place. Security patrols visit each evening, there are security stays on all windows and access into the grounds and the main entrance to the building is controlled via electric doors and gates. Doors and windows are locked at a predetermined time.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>All rooms have natural light and opening external windows. Heating is provided via diesel and electronic wall radiators or ceiling panels with individual controls in residents' rooms and in the communal areas. Residents and families interviewed said the facilities are maintained at a comfortable temperature during all seasons.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The facility implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, and the GM Care Service who is the IPC coordinator. This person liaises closely with all staff and reports at monthly management, health & safety, nurses, and wing meetings. The infection control programme and manual are reviewed annually (last 8 January 2019). The facility has recently purchased new signage and flip charts to help inform and support best practice. The IPC coordinator has clearly defined roles and responsibilities defined within the position description.</p> <p>Staff discourage visitors from visiting the facility when unwell. The infection control manual provides guidance to staff about how long they must stay away from work if they are unwell. Staff interviewed understood these responsibilities. Families interviewed also confirmed their understanding. Staff are required to attend monthly compulsory training and education. All new staff receive training as part of their induction.</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</p> | FA | <p>The infection control coordinator has appropriate skills, knowledge and qualifications for the role. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP, the nurse practitioner and public health unit, as</p> |

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| <p>the organisation.</p> | | <p>required. The RNs are also all members of 'Ko Awatea' education and access Lippincott best practice information and guidelines. The coordinator can access the residents' records and diagnostic results to ensure timely treatment and resolution of infections. There was evidence on the day of audit of resources to support the programme and any outbreak of an infections.</p> <p>The facility uses QPS benchmarking to help inform practice as they are measured against the national industry standards. Information is shared with staff to help support best practice and to ensure any changes for residents are noted and actioned. The interventions are assessed against the next quarter following report to monitor improvements and trends.</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> | <p>FA</p> | <p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were current, referenced and supported with training materials. Care staff, cleaning and kitchen staff were observed following organisational policies, evidenced through good hand washing techniques, use of hand sanitisers and the disposal of aprons and gloves after use. The new owners have increased the number of hand sanitisers in use around the facility. Staff verified their knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <p>Interviews, observations and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the Clinical Educator and supported by the Infection Control Coordinator. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Additional education is provided if there is an increase in infections noted.</p> <p>Education of 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 an increasing fluids during hot weather. It was evidenced at the time of audit extra ice blocks and ice cream was made available due to the hot weather and increasing fluids was reinforced at the residents' meetings. The service has removed large water jugs and replaced with smaller, more 'user friendly' jugs that has seen residents</p> |

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| | | able to take water independently. |
| <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 for a long term facility and includes monitoring of urinary tract, soft tissue/wound, mouth, eye/ear/nose, gastro-intestinal tract and respiratory tract. The infection control coordinator reviews all reported infections and these are documented. Any new infections and any required management plan are discussed at handover, and notifications are sent via the electronic management system to appropriate staff which ensures early intervention occurs.</p> <p>Monthly surveillance data is collected, collated and analysed to identify trends, any causative factors and required actions. Results are shared with staff at various meetings, handovers and all staff have access to the facility computer data base. Graphs are available that identify trends from previous years and are reported to the quality manager. This analysis is to help inform staff knowledge and improve practice. The residents' files reviewed highlighted short term and long term care planning to reduce and minimise the risk of infection. All staff interviewed demonstrated knowledge of residents who have a high risk of infections and the interventions required.</p> <p>There was evidence of staff education and the acquiring of additional resources to help inform practice.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Atawhai Assisi has transitioned to Tamahere Eventides restraint minimisation and safe practice policies and procedures. These meet the requirements of the standards and provide guidance on the safe use of both restraints and enablers. The CNL for the hospital is the nominated restraint coordinator, and the role and responsibilities are documented. This person provides support and oversight for enabler and restraint management throughout the facility and demonstrated a sound understanding of the organisation's policies and procedures and the practices required from this standard.</p> <p>On the days of audit seven residents were using restraints (for example, bed rails and a chair harness) and one resident were using bed rails as a voluntary enabler. The same assessment and consent process is followed for the use of enablers as is used for restraints. The rehabilitation therapist interviewed, described the strength and balancing programmes in place for individual residents to maintain their</p> |

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| | | <p>mobilisation and prevent falls.</p> <p>Restraint is used as a last resort when all alternatives have been explored. Staff are using more low-low beds as alternatives to bed rails. This was evident on review of the restraint register, files reviewed, and from interviews with staff.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>The restraint approval group, comprising the CNL/restraint coordinator, GM Care Services and the general practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the individual use of restraints is being monitored. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator described the documented process which involves them undertaking the initial assessment with input from the other RNs and the resident's family/whānau/EPOA. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Fully completed assessments were sighted in the records of residents who were using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | <p>The use of restraint is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and lazy boy armchairs).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, reviewed and updated every month by</p> |

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| | | <p>the restraint coordinator. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff meeting minutes showed that use of restraint, policy and procedures and related topics are discussed frequently and that staff attend mandatory education on this every year. The staff interviewed understood that the use of restraint is intended to be minimised and how to maintain safety when a restraint is in use.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | FA | <p>Review of residents' files showed that the individual use of restraints is reviewed by the restraint coordinator every three months and evaluated during care plan and interRAI reviews. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | FA | <p>Interview and the documentation sighted (for example RN and staff meeting minutes, resident files, internal audit results) revealed that the restraint coordinator has conducted a comprehensive review of restraint use/trends since the previous audit and consults with the clinical nurse educator (CNE) about whether staff education on restraint requires change.</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.

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|--|---|
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and</p> | CI | <p>Building inspections, staff interviews, review of incident/accident data and quality projects reveal that the service has significantly reduced staff and resident injuries in the previous nine months. Ceiling hoists have been installed in 16 hospital bedrooms with approved budget to install 25 more, until 31 of the 46 rooms will have these fitted. Five bedrooms are not suitable for ceiling hoists. A contract for part time physiotherapist hours was changed to ‘as needed’ and replaced with a full time employed rehabilitation therapist. This person educates and supports staff to safely execute manual handling/transfers and assesses and builds residents’ physical capabilities.</p> | <p>Falls and resident injuries related to manual handling in the hospital area have reduced from 21 falls per month to less than three falls and there are now very few reports of skin tears or bruising. The service is well below and better than a reported industry average of 10.66% of falls in hospital care services. The number of reporting staff injuries related to residents’ cares has reduced to less than five since April 2018.</p> |

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| implemented. | | | |
| <p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p> | CI | <p>Interviews with management, staff and observations on site confirmed improvements to consumer records since the implementation of an electronic records system. The staff responsiveness to the new system has enabled a more holistic, person centred approach to care and has enhanced a multidisciplinary team (MDT) approach. Each resident's primary carer (for example, the GP and nominated care staff) are notified immediately of changes via an electronic message. The GP and CNLs reported that moving to the new system has provided more accountability and speedier attention to residents' changing needs. Care staff were positive and stated the system is more time efficient and effective.</p> <p>The system also links reported accidents and incidents to the resident enabling review of trends/deterioration in independence or capabilities. Comparative reports from before the use of the system to the current day revealed significant improvements in the timing of care plan reviews, with 100% of care plans current on audit day.</p> <p>The GP interviewed said being able to access current and historical information on and off site, encouraged a more comprehensive and thorough medical review and was especially useful for after hour's calls.</p> <p>Daily progress notes can be searched quickly to track changes or irregularities. The GM CS can immediately monitor residents' care needs and run reports for evaluative purposes.</p> | <p>Following the introduction of a new electronic records system, all residents' records are now up to date and reveal the most recent needs assessments and care interventions. Staff reported increased confidence in delivering individual care because they know the information is current and accurate. Residents and family reported increased satisfaction with the detail and level of information provided to them.</p> |

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| <p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p> | <p>CI</p> | <p>A need for improvement was identified through family and resident feedback about the taste, quality and consistency of the pureed food on offer. The organisation introduced a new system of moulded food in late 2018. This has resulted in residents increasing their nutritional intake, improved food presentation (evidenced at time of audit) and reduced choking risks. In the last six months, there is evidence of just under 50% of those residents on the new food system having increased weight and sustained weight gain for this group of identified frail residents. Resident satisfaction with meals was verified by resident and family interviews. One family member reported their relative has increased weight and showed interest in food again since the introduction of the new methods. Residents were observed to be provided with sufficient time to eat their meal in an unhurried fashion despite the numbers of residents requiring assistance. Staff reported less wastage and less complaints have been received. Staff have been provided specific training and all the tools required to implement and monitor the system. The success of this project has been recorded on video for shared learning.</p> | <p>Following the introduction of a new food system data analysis shows that nearly 50% of frail residents have improved or maintained weight by increasing their nutritional intake. There is significantly less food being wasted and returned to the kitchen, resulting in cost savings for the organisation. Families and residents interviewed said the food presented looked like the food on the menu and was very palatable. There have been fewer incidents of choking reported.</p> |
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End of the report.