Te Hopai Trust Board - Te Hopai Home and Hospital

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Te Hopai Trust Board
Premises audited:	Te Hopai Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 March 2019 End date: 19 March 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 148

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Hopai Home and Hospital is governed by a charitable Trust and provides rest home, hospital (medical and geriatric) and dementia level care for up to 151 residents. There were 148 residents on the days of the audit.

This surveillance audit was conducted against aspects of the Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of residents and staff files, observations of practice, as well as interviews with residents, family, management, staff and a general practitioner.

Te Hopai has a general manager who is responsible for the management of the service. She is supported by a management team including a clinical manager, a quality and training manager, a managing trustee (a board member) and care managers in the rest home and dementia unit. There are well developed systems that are structured to provide appropriate quality care for residents. Residents and family members interviewed spoke highly of the services provided at Te Hopai.

This audit has identified no areas requiring improvement.

The service continues to exceed the required standard around quality management, the management of nutritional requirements and infection control surveillance.

Consumer rights

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

Communication with residents and family was evidenced in files and documentation reviewed. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Te Hopai Charitable Trust board provides governance and support to the general manager. There is a documented strategic plan and quality programme. Internal audits are completed as per the audit schedule and corrective actions are documented. Benchmarking is conducted, and quality data is used to improve outcomes for residents. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

Registered nurses are responsible for each stage of provision of care. Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process.

The diversional therapists and activity coordinators provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied, interesting and meets the recreational needs and preferences of each resident group.

There are policies and processes that describe medication management. Registered nurse and care staff administering medications complete annual competencies. An electronic medication management system is in use. The GP reviews medication charts three monthly.

An external contractor is contracted to provide the food service. All meals are prepared on site. The dietitian has reviewed the menu. Residents' food preferences and dietary requirements are identified at admission and reviewed six monthly or earlier as required. There has been dietitian review of the menu. There are nutritious snacks available 24 hours in the dementia unit.

Safe and appropriate environment

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

The building holds a current warrant of fitness and a preventative and reactive maintenance programme is implemented.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there were no restraints and 22 enablers in place. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection prevention and control

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

The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	15	0	0	0	0	0
Criteria	4	37	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. A complaints procedure is provided to residents within the information pack at entry. The complaints register was reviewed for 2017 and 2018 and includes written and verbal complaints, dates and actions taken. Complaints are managed in a timely manner. There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented. This includes one complaint to the HDC in December 2017. Documentation was sighted relating to response, follow-up and corrective actions completed. A letter was sighted from the HDC in September 2018 stating no further follow-up was required. The complainant has also responded that no further action is expected. This complaint has been signed off and resolved.
Standard 1.1.9: Communication Service providers communicate	FA	The manager and staff were able to identify the processes that are in place to support family being kept informed. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Family are notified of incidents and accidents and changes in resident condition as evidenced on incident reports and in progress notes, and on interview with family members. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident

effectively with consumers and provide an environment conducive to effective communication.		should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. A site-specific introduction to the dementia unit providing information for family, friends and visitors to the facility is provided to family.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Te Hopai is owned and operated by a Charitable Trust Board with a high level of appropriate skills and expertise. A managing trustee provides support to the general manager and provides a liaison point between the general manager and the board. The organisation chart describes the general manager, who has been in the position for 14 years, is supported by a clinical manager, a quality and training manager, a rest home care manager and a dementia care manager. Te Hopai Home and Hospital provides hospital (medical and geriatric), rest home and dementia level care for up to 151 residents across four units. The Kowhai dementia unit has 16 beds and was full at the time of audit with all residents on the age-related care contract (ARCC). The 'Hospital' is a 41-bed dual purpose unit. On the day of the audit there were 41 residents – 35 at hospital level care (including two on ACC contracts) and six rest home residents all on the ARRC contract. The Owen Street building (the complex is all one building, with this being the newest addition in 2015) is two levels and all beds in this area are dual-purpose. Level 1 has 21 beds. At the time of audit there were 20 residents: one rest home level resident and 19 hospital level residents. Level 2 has 26 beds with 25 residents at the time of audit. Twenty-two residents were receiving hospital level care and three residents were receiving rest home level care. The rest home unit has 47 dual service beds. At the time of audit there were 46 residents, with all residents on the ARCC. There were 17 rest home residents and 29 hospital level care. The management team have maintained at least eight hours annually of professional development activities related to managing a hospital. Te Hopai has both a five-year business plan and a risk management plan. The quality plan is separate from this and is reviewed and rewritten every year. The objective of the quality plan is to ensure that the goals and objectives of service delivery are achieved. These goals are determined by the Ministry of Health standards, the district health board contract and the needs and wishes of the residents and relatives as established by the satisfaction surveys that are sent out every year.
Standard 1.2.3: Quality And Risk Management	FA	Te Hopai Home and Hospital has a well-established quality and risk management system which is overseen by two part-time quality and training managers (QM). The quality plan includes a variety of quality goals that are developed annually. A comprehensive annual quality review report, documents progress toward all goals and reports on all

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		areas of the benchmarking results. The service continues to effectively use an Australasian internal auditing and benchmarking programme. Benchmarked results and review of data generate ongoing improvements in service delivery. Audit summaries and action plans are completed where a non-compliance is identified. Issues are reported to the appropriate committee (eg, quality). The service is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and benchmarking reports. When shortfalls are identified, comprehensive corrective action plans are developed, shared, implemented and reviewed using a PDCA model to ensure these are addressed. The service continues to exceed the required standard in this area. Interviews with staff and review of meeting minutes/quality reports demonstrated a culture of quality improvements. Quality and risk performance are reported across the facility meetings, through the communication book, and to the trust board. Key components of the quality management system link to the monthly QM reports through quality reports provided from departments. Monthly reports by the general manager to the Board of Trustees provides a coordinated process between service level and board level. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Health and safety continue to be managed by the GM with the health and safety committee meeting monthly. The service works to a “health and safety vision” through the meetings and the implementation of policies and procedures and day-to-day monitoring by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Detailed review of falls incidents has resulted to improved documentation around residents at more risk of falling and this has reduced falls in this group.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and	FA	The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. A review of 16 incident forms from across all areas demonstrated that individual incident reports were completed for each incident/accident, with immediate action noted and any follow-up action required. The data is linked to the internal benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and all other facility meetings reflected discussion of incidents, trends and corrective actions required (link CI 1.2.3.8). Three section 31 notifications have been appropriately made since the last audit – two for stage three pressure injuries and one for a behavioural incident. Discussions with service management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications.

where appropriate their family/whānau of choice in an open manner.		
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The service maintains a register of registered nurses' and allied health provider's practising certificates. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (three caregivers, three registered nurses, one diversional therapist, and the clinical manager), contained evidence of appropriate human resource management practices. All files had up-to-date performance appraisals. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. The service no longer completes an orientation programme that was matched with an education provider for a level two qualification. Staff interviewed could describe the orientation process and stated that they believed new staff were very well orientated to the service. The service employs two staff to oversee education and training for staff. There is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence in RN staff files of attendance at the RN training days, DHB training, postgraduate education opportunities, hospice training and other external training. Level two and three qualification training is available for caregivers. The service is currently implementing a literacy and numeracy support group for staff for whom English is a second language. This has been developed in response to feedback from residents that they sometimes have difficulty understanding staff and staff also acknowledged that they wanted to be able to communicate more effectively with residents and understand New Zealand culture. A competency programme is in place. Core competencies are completed annually or bi-annually depending on requirements. The quality and training manager maintain a comprehensive database to ensure competencies are maintained. There are 11 caregivers employed to work in the dementia unit. Eight of these and the diversional therapist have completed the required dementia unit standards. The other three caregivers have been recently employed. One of these three caregivers have commenced studying the required unit standards and two are yet to start. These two staff commenced employment in the last six months.
Standard 1.2.8: Service Provider	FA	There is a roster for each area that aligns with contractual requirements and includes skill mixes. The care managers, clinical manager and general manager reported that the board supports high standards of care and

Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		funds staffing to ensure this. This was confirmed by the managing trustee. Several of the management team, including the general manager, education coordinators, clinical manager, rest home and dementia care managers and the quality and training manager are registered nurses. In Owen Street Level one there is one registered nurse on morning shift and one on afternoon shift In Owen Street level two there is also one RN on morning shift and one on afternoon shift. One registered nurse covers both Owen Street wings overnight and is based on the floor with the highest acuity at that time. In the hospital, there are two registered nurses on morning shift, one on afternoon shift and one on night shift. In the dementia unit, there is the care manager (registered nurse) on duty during the day, during the week. In the rest home, there are two registered nurses and a care manager (registered nurse) on morning shift, and one on afternoon shift and one on night shift. The registered nurses are supported by rostered caregivers. Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier and resident acuity levels were higher.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medication policies and procedures in place that meet legislative requirements. All clinical staff who administer medications are competency assessed and attend annual medication education provided. The RNs have completed syringe driver training. The pharmacy provides the blister packs, and these are checked by the RN on delivery against the electronic medication chart. Discrepancies are reported back to supplier. Medications are stored safely in each unit. There is an impress stock held in the hospital with regular checks on stock levels and expiry dates. Standing orders have been reviewed annually by three GPs. Each unit has a medication fridge with weekly temperature recordings that are within the acceptable ranges. All eye drops sighted in the medication trolleys were dated on opening. There were two residents self-medicating (hospital) with self-medication competencies completed and reviewed. Sixteen medication charts on the electronic medication system were reviewed (eight hospital, four dementia and four rest home) identified that the GP had reviewed the resident medication chart at least three monthly. All medication charts sampled had photo identification and allergies/adverse reactions documented. All medication charts sampled met legislative requirements. The use of ‘as required’ medications are monitored and signed with times when administered. The effectiveness of ‘as required’ medications was recorded in the electronic medication system and in the progress notes. Medication administration observed demonstrated compliance of medication administration.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at Te Hopai Home and Hospital are prepared and cooked on the premises. A catering company is contracted to provide this service. There is a Food Control Plan in place. The four weekly seasonal menus have been reviewed by a dietitian. The menu includes alternative meal options. Vegetarian, gluten free, dairy free, halal and modified/soft/pureed meals are provided as required. There is a continental breakfast and the main meal is at midday. In addition, nutritious snacks are available for residents in the dementia care area 24 hours. Meals are plated, covered and delivered to the areas in scan boxes. The chef receives a nutritional profile with allergies, needs, likes and dislikes noted for each new resident. The chef also receives a daily updated list with individual resident meal choices, specific dietary requirements and updates about any residents with weight loss. The chef confirmed that high protein and high calories foods are provided for any residents with unintentional weight loss. The serviced has maintained a continual improvement rating around weight management. The chef meets with residents and their families and completes a survey tool to monitor satisfaction. Residents and relatives interviewed expressed satisfaction with the meals. End cooked and serving temperature monitoring is carried out on hot food daily. The walk-in chiller, fridges, freezer and dishwasher temperatures are monitored daily. There is a chef/site manager, cook and two kitchenhands on duty daily. The chef and cook are qualified. All kitchen staff have been trained in safe food handling. The company who holds the chemical supply contract, conduct quality control checks on the dishwasher and monitor chemical usage and effectiveness. Chemicals are stored safely. The catering company are externally audited.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. Residents and relatives interviewed, stated the residents' needs are being met. Significant events and communication with families are documented on the family consultation form and in progress notes. Short-term care plans are utilised for short-term needs and supports. These are evaluated regularly to monitor progress against the interventions to meet the resident goals. Long-term care plans are updated to reflect changes in care and supports required to meet the resident needs. Adequate dressing supplies were sighted in the treatment rooms. There are policies and procedures for wound care management. A review of 25 wounds included skin tears, chronic ulcers, non-healing lesion, surgical wound and pressure injuries. All wounds had wound assessments and evaluations completed as per documented frequency which included photographs, size of wound and body maps showing location of wound. There was one stage three community acquired pressure injury. There were three facility acquired pressure injuries (one stage one and two stage two). The district nurses have been involved in the stage three pressure injury management and

		non-healing and complex wounds. The RNs could describe access to district nurses and wound care specialists as required. Wound care education has been provided. There are adequate pressure injuries resources as viewed on the day of audit. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and RNs. Continence management in-services have been provided. Monitoring charts include vital signs, neurological observations, weight charts, behaviour charts, pain monitoring, bowel charts, food and fluid charts and blood sugar level monitoring.
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.	FA	Te Hopai Home and Hospital has three diversional therapists and two activity coordinators. The team includes an enrolled nurse and one member with a Bachelor of Education who is completing her diversional therapy qualification. They coordinate a Monday to Friday programme in the rest home and hospital wing. A DT and activities coordinator provide a seven-day week programme in the dementia unit. The diversional therapy team are supported by a group of volunteers who visit throughout the week and assist residents with activities. The hospital, rest home, dementia and Owen Street level one and two have separate programmes. Each activity programme is designed to meet the resident's physical and cognitive needs. Monthly programmes are displayed in all rooms. Each month there is a different activity theme. There are integrated activities such as entertainment and church services held in the large rest home main lounge. Dementia care residents attend (as appropriate) integrated activities under supervision. Families are encouraged to attend activities of interest including happy hours and music. One-on-one time is allocated on the programme for residents who are unable to participate in group activities or prefer to stay in their room. There is evidence of one-on-one time with residents in the individual monthly progress notes. The men's group is popular and has a grief management component facilitated by a visiting minister. The music group is well attended, music is chosen that is meaningful for the residents. The community van (with wheelchair hoist) and a car are used for weekly outings. All staff have completed First Aid certificates. The activities for residents in the dementia unit are flexible, meaningful and allow for impromptu activities to be included. The DT has implemented a gardening project involving residents in many and varied ways from planting, watering to picking the flowers. The art and craft programme encourages residents to create their own work as demonstrated by photographs. There are regular pet therapy visits and sing-a-longs. Residents in the dementia unit have activities to manage behaviours including de-escalation activities, gardening and craft projects. The lifestyle plans for residents in the dementia unit include a 24-hour behaviour management plan that includes activities. An activities staff member works with residents and their family/whānau on admission to build a personal profile for

		the resident. An activity assessment and lifestyle care plan are developed for each resident within three weeks of admission in consultation with the resident/family/whānau. Attendance sheets and individual monthly progress notes are maintained. Reviews take place every six months or sooner if the resident's needs change in consultation with the RN and MDT. Resident meetings are held once a month in the rest home. Feedback on the programme is received through resident meetings and regular surveys. Residents interviewed stated they enjoy the activities, entertainers and outings provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident files reviewed demonstrated that the long-term care plans were reviewed at least six monthly or as changes occur. Each section of the care plan has a written evaluation where goals have been met or unmet and the care plan updated to reflect the outcome of the evaluations where different from expected. Six monthly multidisciplinary team (MDT) reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the residents' care. The family is invited by letter to attend the MDT meeting and if unable to attend they are informed of any changes to care. Family members interviewed reported they were involved in all aspects of care and reviews/evaluations of the care plans.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 28 June 2019. There is a preventative and reactive maintenance programme in place. All equipment is calibrated, and electrical equipment tested. Hot water temperatures are monitored. Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors including a large secure garden in the dementia unit. There are quiet, low stimulus areas that provide privacy when required. The facility is well maintained inside and out and has safe paving, outdoor shaded seating, lawn and gardens
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that	CI	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IPC coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the IPC coordinator. The infection control programme is linked with the quality management programme. Results of infection control data collated is graphed and discussed at staff meetings. Infection control is internally benchmarked which continually compares infection control data gathered.

have been specified in the infection control programme.		Systems in place are appropriate to the size and complexity of the facility. Quality Improvement initiatives are taken and recorded and have resulted in improved outcomes for residents to a level that continues to exceed the required standard.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Te Hopai has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers and restraints should these be required. The policy includes that enablers are voluntary and the least restrictive option. There were 21 residents with 22 enablers at the time of the audit and includes one resident with a lap belt and a bed rail. One other resident has a lap belt and all other residents with enablers have bed rails in place. Either the resident or their EPOA signs consent to ensure voluntary (sighted in three files sampled). There were no residents having been assessed as requiring restraint at the time of audit. Strategies are in place to minimise the use of restraint including, sensor mats, hi-low beds, mobility aids and regular observation of residents however, the number of enablers has increased from nine to 22 since the last audit. A risk assessment of bed rails has been conducted for each resident with an enabler and the quality manager has completed a gap analysis. The service has implemented the use of an information sheet for residents and family on admission on the use of bed rails and the risks involved. The registered nurses also have access to an algorithm to assist them in the decision making around restraint and enablers. All bed rails have covers on them.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	The service continues to benchmark using an Australasian programme. The benchmarking programme provides comprehensive information, which is reviewed by the management and quality team and quality managers. When unwanted trends are identified, the quality managers undertake research, including a review of published literature on the subject and access any required expertise. A corrective action plan is then developed and implemented, and outcomes reviewed to address specific areas where results are outside the desired benchmark or showing an unwanted trend. The service continues to exceed the	The service is proactive in identifying unwanted trends and developing and implementing corrective action plans to address the issue. Benchmarked data from 2016 identified higher than desired numbers of incidents of aggression and undesired behaviours in the resident population, particularly in the dementia unit. Actions include taking a more proactive approach to evaluating and changing care plans of residents involved in incidents and arranging early assessment and interventions from the psychogeriatric team. The psychogeriatric team have provided positive feedback about the quality of the behaviour logs and behaviour monitoring that occurs. Training around dementia including the causes and why people behave the way they do continues to be provided annually. The staff use alternative therapies to reduce behaviour wherever possible, including massage which is funded by the facility. The staff newsletter continues to provide information for staff on incidents and accidents including behaviour incidents. The downward trend in aggressive incidents toward other residents and aggressive incidents towards staff (benchmarked separately) continues. Aggressive incidents in 2016 were 35; in 2017 they were down to 9 and in 2018 down to 4.

		standard in this area.	
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	The service has continued to implement effective weight monitoring tools that identify early unintentional weight loss. Prompt interventions have resulted in reducing significant unintentional weight loss.	Monthly weights are conducted monthly on all residents. A nutritional risk assessment is completed on all residents on admission which identifies any residents at risk of weight loss. Weights are increased to weekly for any resident at risk or with early weight loss. Interventions are implemented including high protein and high calories foods. The chef confirmed on interview he is notified of any residents with unintentional weight loss and provides foods as instructed by the RNs. Three files of residents with slight unintentional weight loss in the last six months were reviewed. The weight monitoring charts evidenced the weight loss had been halted within a month of being identified and all three residents had a weight gain the following month. Long-term care plans had been updated to reflect the resident's current nutritional status. The service benchmark against Australian aged care standards (MOA – moving on audits) and graphs/data evidence the service is well below the benchmark count for the last six months and there were no residents with unexpected weight loss in the last four months. The service has maintained a continuous improvement rating around weight loss management.
Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and	CI	The quality and training manager and infection prevention and control manager undertake research and attend relevant meetings, conferences and trainings to ensure they are aware of current best practice. The service is able to provide funding for their contracted medical practitioners to expand their knowledge if required. The service has continued to exceed the standard in this area.	In early 2016, the infection control team identified that 13% of antibiotics prescriptions did not meet the antibiotics prescribing criteria. The service accessed and provided a copy of the antibiotic prescribing guidelines to all GPs to encourage appropriate prescribing. Training and collegial support was provided to registered nurses to enable them to feel more able to discuss prescribing practices with the GPs. The improvements made in 2016 have been maintained with respect to appropriate antibiotic use with 71% recorded use of nitrofurantoin or trimethoprim as the first line of treatment for urinary tract infections (best practice). With the remaining 29% it was identified that half came back as resistant to nitrofurantoin or trimethoprim. The service experienced an outbreak in August 2018 with 17 cases identified - 10 residents and 7 staff. The changes and improvements made the previous year were implemented at the 2018 outbreak. Family were allowed to visit using full PPE gear at set visiting hours. Visitors were accompanied by a staff member to ensure infection control and that people sanitised on

complexity of the organisation.			entry and exit. Consumer satisfaction increased, and no complaints were received during the last outbreak in contrast to the previous outbreak. The service was commended by Public Health for maintaining low numbers of infected residents and staff during this latest outbreak.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The service develops annual quality goals and infection control goals are included within these. Detailed reporting and monitoring and comprehensive analysis of benchmarking results have resulted in continued improvement to practices by staff.	In 2016 the Te Hopai infection control team determined to lower the rate of cellulitis for all residents and UTIs for hospital level residents (who were highest in the statistics). The McGregor form was researched and used to ensure that infections were accurately diagnosed and there was a concentrated and ongoing programme to increase hand hygiene and reduce glove use to protect residents from increased risk of infection. Frequent hand hygiene audits underpinned and monitored this process. The service also researched and sourced high standard training material for staff including video tutorials from the Ontario Public Health programme. Additionally, staff awareness was increased around reducing the risk and incidence of residents bumping and bruising themselves as it was identified that this was a precursor to many of the cellulitis infections. The service continues to use the Ontario public health video for training, conducts tutorials for staff and completes regular hand hygiene audits. The number of residents with cellulitis continued to reduce with numbers in 2015 – 51; 2016 – 31; 2017 – 24 and 2018 – 29. Education and training for staff has also been provided around urinary tract infections (UTI) and diagnosis. The service has maintained UTI rates below benchmark rates for 2018 and 2017.

End of the report.