

# The Hillview Trust Incorporated - Hillview Home and Hospital

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## 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:

<b>Legal entity:</b>	The Hillview Trust Incorporated
<b>Premises audited:</b>	Hillview Home and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 30 May 2019    End date: 31 May 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	45

# Executive summary of the audit

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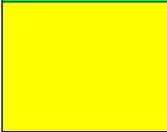
## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Hillview Home and Hospital provides rest home and hospital level care for up to 52 residents. The provider meets the needs for hospital medical services and the funder from Waikato District Health Board supports this. The service is operated by The Hillview Trust Incorporated.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with the. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner. Residents, their families and the general practitioner spoke positively about the care provided.

Significant changes since the 2018 surveillance audit are renovations to the interior, the installation of CCTV and the resignation of the previous general manager. The clinical manager is currently acting as the general manager with assistance and support from the housekeeping manager and the board.

This audit identified one area requiring an improvement related to the environment. There have been significant improvements in service delivery. A rating of continuous improvement is acknowledged in adverse events for the success achieved with significantly reducing resident falls.

## Consumer rights

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

Standards applicable to this service fully attained.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

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

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes internal audits, and the collection and analysis of quality improvement data. This data is benchmarked with seven other facilities and identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families.

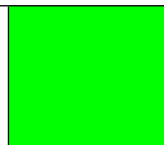
Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery, were current and are being reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

## Continuum of service delivery

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



Standards applicable to this service fully attained.

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

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

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

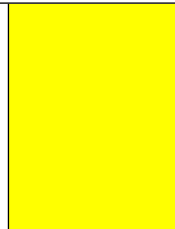
The planned activity programme is overseen by a diversional therapist and a recreation coordinator and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

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



Some standards applicable to this service partially attained and of low risk.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Bulk laundry is cleaned off site by an external contractor; therefore only resident's clothes and other smaller items are laundered by staff onsite. Cleaning and laundry services are monitored and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained. Communal and individual spaces are maintained at a comfortable temperature.

## Restraint minimisation and safe practice

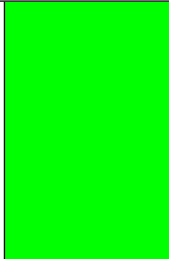
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. On the days of audit four residents were using restraints and six had enablers in use at their request and with their consent. Staff demonstrated a sound knowledge and understanding of alternatives to restraint and what to do if restraints or enablers are assessed as being needed.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	48	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Hillview Home and Hospital (Hillview) has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</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' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints have been received since the beginning of 2019 and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The clinical manager is currently responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents of Hillview and family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were eight residents in Hillview at the time of audit who identified as Māori. Interviews with staff, residents and their family verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from local cultural advisers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	<p>FA</p>	<p>Residents of Hillview, when interviewed, verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed; for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>During interviews, residents and family members of residents stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, physiotherapist, renal nurse specialist, wound care nurse specialist, services for older people, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided, evidenced by an ongoing initiative aimed at a reduction in the number of falls and resulting fractures (refer criterion 1.2.4.3). An improvement in the activities provided to enable improved resident's participation in a wide range of activities on offer. A reduction in medication errors has occurred following the implementation of an electronic medication management system. A high level of satisfaction with the caring environment provided at Hillview was a continual theme mentioned in all resident and family interviews.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Interpreter services can be accessed via Te Kuiti Hospital. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> <p>Residents of Hillview have access to free Wi-Fi and are enabled to communicate with outside sources as desired.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the trust board showed adequate information to monitor performance is reported including emerging risks and issues.</p> <p>The Clinical Manager has been acting in the general manager (GM) role since February 2019, with day to day support from the household manager and the board. Interviews for the role have been occurring. Senior management and the board maintain knowledge of the sector, regulations and reporting requirements by attending regular meetings with other aged care managers in the Community Trust Care Association (CTCA) Community Trust Care Association is a business entity set up by of group of aged care facilities who are located rurally and governed by not for profit organisations.</p> <p>The service holds contracts with Waikato DHB for hospital-geriatric, rest home, palliative, long term support-chronic health conditions and respite care. On the first day of audit, there were 45 residents on site. Nineteen of these were rest home level care and 23 were hospital level care including one resident on respite. There were an additional three people under the age of 65 years with long term support-chronic health conditions. Two were assessed at rest home level care and one at hospital level care.</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>	<p>FA</p>	<p>When the GM is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>	<p>FA</p>	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents including infections and complaints, audit activities, regular resident and family satisfaction surveys, internal audits and the monitoring of outcomes. All incidents/accidents, infections, restraints and complaints are collated as quality data, analysed and compared month by month for trends. An overview of this data is reported to the board each month. A sample of meeting minutes confirmed that this data and other related information is also discussed at the weekly senior leadership team meeting, and to the monthly health and safety meetings, registered nurse (RN), health care assistant (HCA) and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at their meetings.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Results of the most recent survey showed a high level of satisfaction and no significant issues.</p> <p>The sample of policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Interviews with two board members and all members of the senior leadership team demonstrated how they monitor and manage risks, and their responsibilities under the Health and Safety at Work Act (2015). There have been no serious staff injuries.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>CI</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed. All incidents are reviewed by the senior leadership team and signed off by the clinical manager (CM). Where further investigation or improvement is required, corrective actions are recorded and there are processes to ensure actions are implemented and then closed off in a timely manner. A range of adverse event data, for example, falls-with and without injury, urinary tract infections (UTIs) and skin tears is collated, and reported to CTCA for benchmarking each month. Hillview's month by month data analysis reports are discussed at all staff meetings and pictorial graphs are on display in the staff training and handover room. A mobility improvement plan initiated in late 2018 which succeeded in significantly reducing resident falls, is rated continuous improvement in criterion 1.4.2.3</p> <p>The acting GM described essential notification reporting requirements, including for pressure injuries. There have been three notifications of significant events made to the Ministry of Health and DHB since the previous audit. These include a stage four pressure injury in April 2019, an unexpected death in October 2018 which was reviewed by the coroner, and the change of manager in February 2019. There have been no police investigations, or issues based audits.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes police and referee checks, 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. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review at the end of 90 days.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are two registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments and one more is due to complete this. All of the RNs have undertaken training in peritoneal dialysis.</p> <p>Each of the staff records reviewed contained evidence of attendance at regular training and participation in an annual performance appraisal. All of the RNs hold current first aid certificates and are peer assessed annually for medicine competencies. Some of the senior HCAs are maintaining competencies in medicine administration, and although they do not administer medicines they act as verifiers of controlled drugs.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents as determined by the resident's current needs and acuity. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All RNs and some senior HCAs hold a current first aid certificate ensuring at least one person is on site with a current certificate. There is 24 hour/seven days a week (24/7) RN coverage.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and</p>

<p>uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the clinical manager (CM). Written information about the service and the admission process is provided.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Waikato District Health Boards (WDHB) 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to another care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</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</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guides for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These</p>

<p>guidelines.</p>		<p>medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administers inhalation medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and meet guidelines.</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>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in November 2017. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Waitomo District Council. A verification audit of the food control plan took place 27 September 2018. Areas identified as requiring improvement have been addressed.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified in resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen</p>

		to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.
Standard 1.3.2: Declining Referral/Entry To Services  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.	FA	If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made. A new placement is found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents of Hillview are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission new residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months, or more frequently as residents changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified the RNs are familiar with the requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.  All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented

continuity of service delivery.		and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
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	<p>The activities programme is provided by a diversional therapist Monday to Friday and an activities coordinator on the weekend.</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 meaningful to the residents. The residents' activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme is diverse and matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. An initiative aimed at reducing the number of falls, and fractures includes a morning exercise programme implemented with guidance from the physiotherapist. Each week residents peel the vegetables they have grown in their vegetable garden, to make the vegetable soup. Once a week, the residents do the baking for the afternoon tea request that day. A diverse range of activities are observed to occur each day. Articles knitted by residents are on display for sale, as are several trinkets and artwork the residents have made. Community involvement and participation at Hillview is high. Entertainment is observed to occur each day. The activities programme is discussed at the monthly minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs. An interview with a resident under 65 years verified Hillview staff support the resident to participate in community activities as desired.</p>
Standard 1.3.8: Evaluation	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of 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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</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 with expiry date 01 July 2019, is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Three of the hospital designated bedrooms have been completely refurbished with plans to continue updating the remaining rooms as funds become available.</p> <p>Residents and staff said that they are happy with the environment and confirmed they know the processes they should follow if any repairs or maintenance is required. Review of maintenance journals demonstrated that requests were appropriately actioned in a timely manner.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>PA Low</p>	<p>All of the bedrooms have a hand basin. The hot water temperatures are tested monthly, and the records sighted show no temperatures over 45 degrees in residents rooms. There are six bedrooms with full ensuite bathrooms, and six with their own toilets, otherwise residents use the shared toilet/shower facilities. There are adequate numbers of these located in close proximity to resident bedrooms and common areas. All of the bathrooms inspected were in good condition, apart from one shower room which requires new wall linings. An improvement is required.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>Of the 52 bedrooms available, eight are designated for hospital level care and a further 11 are designated as dual service beds. Three hospital bedrooms and a whanau room have been fully refurbished with new furniture, curtaining, floor and wall surfaces. The renovated rooms provide plenty of easily accessible storage, a flat screen wall mounted television, easy chair and hospital bed. Renovations include features that mitigate</p>

setting.		<p>property damage such as wall guards. The plan is to refurbish all of the west wing bedrooms as funds allow.</p> <p>There is room on site to store mobility aids, wheel chairs and mobility scooters. Residents and their families were happy with the bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There is one main dining area and a large lounge which are easily accessible for residents and staff. Additional to this are four smaller lounges for residents to use for visits or privacy, if required. Furniture is appropriate to the setting and residents' needs. Improvements have been made to the way the dining area is utilised. People who require assistance with eating, begin their meals half an hour earlier, which means they have sufficient time to finish their meals.</p> <p>The recreation room/main lounge is very well utilised by all residents who are provided with a range of entertainment and activity there.</p>
<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>Bulk laundry services are provided by an external contractor who collects and delivers laundry three times a week. Residents' clothing and other small items are laundered on site in a fit for purpose laundry by a designated laundry staff member six days of the week. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Designated cleaners are on site for up to six hours each every day. They attend regular training in subjects appropriate to their roles, as confirmed in interview and sighted in rosters and training records. Chemicals were stored in lockable cupboards and were in appropriately labelled containers. All areas inspected throughout the facility were spotlessly clean. The methods for cleaning are reviewed and new systems are introduced if required. Residents and their families commented that the home was always clean and odourless. Cleaning and laundry processes are monitored for effectiveness through the internal audit programme. These audits have revealed no issues of concern</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</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 describe the procedures to be followed in the event of a fire or other emergency. The fire evacuation plan is approved by the New Zealand Fire Service. Trial evacuations are taking place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in December 2018.</p> <p>The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the</p>

<p>emergency and security situations.</p>		<p>emergency procedures.</p> <p>Civil defence stores include food, blankets, mobile phones and portable gas to provide for a maximum of 52 residents and staff for up to five days. The system was sighted and discussed with the household manager and maintenance personnel. The site uses town supply water and has an additional 1000 litres of water for emergency use. There is a generator on site. Emergency lighting is regularly tested and often used because of frequent power outages.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Doors and windows are locked each evening at a predetermined time to maintain security. There have been no security incidents in recent years. Since the previous audit, a closed circuit television system has been installed in main areas primarily for use in reviewing unwitnessed incidents. Residents, families and staff were all informed and have no issues with the CCTV system.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, and opening external windows. Heating is provided by heat pumps in the common areas and portable fin radiator heaters in residents' rooms. More cost effective heating systems are being trialled. All parts of the home were warm and well ventilated throughout the audit and residents and families confirmed the environment is maintained at a comfortable temperature.</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>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual that was developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the CM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM and tabled at the senior leadership meeting, staff meeting and the health and safety meeting. The infection control committee meets three monthly to discuss any infection control concerns. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities.</p>

		Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has appropriate skills, knowledge and qualifications for the role; however, has been in this role for only a short time and is being assisted by the CSM. The infection control coordinator has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.  The infection control coordinator and CM confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures  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.	FA	The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education  The organisation provides relevant education on	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the infection control coordinator.

<p>infection control to all service providers, support staff, and consumers.</p>		<p>Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover to ensure early intervention occurs.</p> <p>The infection control coordinator and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the CTCA group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service provider's policies meet the requirements of these standards and provide guidance on the safe use of both restraints and enablers.</p> <p>On the days of audit, the restraint register listed four residents using bed rails and/or lap belts and fall out chairs as restraint interventions and six residents using bedrails as enablers</p> <p>The same assessment and consent process is followed for the use of enablers as is used for restraints.</p> <p>Four residents' records reviewed, contained evidence that a comprehensive assessment of the resident's status and risks had been conducted prior to implementing a restraint intervention and that alternatives had been tried. Approval to use restraints are granted by the general practitioner, and restraint committee and valid consent is obtained by either the resident or their authorised next of kin (NoK). There was evidence of ongoing monitoring and review of each restraint intervention.</p> <p>Training records and interviews showed that all staff attend at least one education session on restraint and management of challenging behaviour and use of de-escalation each year. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.</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>	<p>FA</p>	<p>The CM has recently designated another RN as the restraint coordinator (RC). The role and responsibilities are contained in a position description which describes oversight of all restraint in use with support from the restraint committee. 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>The restraint approval committee is comprised of the CM, the RC, a senior HCA, and a Health and Safety representative. The committee convenes every three months or as needed to review and consider restraint assessments and make approval. There was clear approval for use of restraint on the records reviewed and interview with the coordinator confirmed clear lines of accountability. 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>	<p>FA</p>	<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 sign off is part of the decision to use a restraint intervention. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome for all restraint use was to ensure the resident's safety, security and promote mobilisation. 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>	<p>FA</p>	<p>The use of restraint is actively minimised through the use of low beds, alarm mats and shaped mattresses to prevent any rolling out of bed.</p> <p>The alternatives considered and trialled were documented in the restraint forms and in the care plan. All staff are aware of alternatives and seek new ideas.</p> <p>The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated. An electronic restraint register is maintained, reviewed and updated by the restraint coordinator whenever a change is made. The register sighted contained all residents currently using a restraint and sufficient information to provide an auditable record.</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</p>

		<p>dignity and privacy are maintained and respected.</p> <p>Staff meeting minutes showed that use of restraint, policy and procedures and related topics are discussed frequently. Staff attend mandatory education and must pass an annual restraint competency test. 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 within three weeks of commencing use and then re-evaluated during care plan and interRAI reviews every six months. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of this 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, a sample of restraint committee meeting minutes, and the documented 2019 quality review, RN and staff meeting minutes, confirmed that a comprehensive review of restraint use/trends has occurred since the previous audit. The restraint coordinator consults with the clinical manager about the frequency and efficacy of staff education on restraint and whether changes are required.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	PA Low	<p>There are sufficient toilets and showers and a bed bath located throughout the facility. These are being upgraded as funds allow.</p> <p>The walls in one shower room require repair. The materials for repair were procured during the audit and maintenance staff stated that replacement will be completed within five working days, which is why the timeframe for this corrective action is 30 days.</p>	The wet wall linings of a shower cubicle in the far west wing are degraded and broken at the base which poses a risk.	<p>Replace wet wall lining to ensure the surfaces are intact to provide good infection control and hygiene.</p> <p>30 days</p>

## 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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>A plan to reduce resident falls was initiated in November 2018. At the time there were more than 20 falls being reported each month and six of these resulted in fractures (one required surgery). An internal audit showed 30% of residents had never been assessed by the physiotherapist and 90% did not have individual exercise plans. The CM and contracted physiotherapists agreed to a number of actions which included more targeted physiotherapy input so at least five residents were assessed each week, and reviewed at the same time as their interRAI reassessments were due, allocating an HCA as a physiotherapy assistant, and implementing daily group and 1:1 strengthening and balancing exercises,</p> <p>All residents have now been assessed and 100% have their own exercise pictograms in their room. Mobility ‘Q’ cards have been developed for each hospital resident. Every new resident is assessed by the visiting physio within a week of admission,</p>	<p>Falls have reduced from on average 22 per month to less than 10 a month as a result of more focused interventions to enhance the falls management program. There have been no fractures to date this year.</p>

End of the report.