Orewa Beach View Retirement Home & Hospital Limited - Solemar

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Orewa Beach View Retirement Home & Hospital Limited
Premises audited:	Solemar
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 16 July 2019 End date: 17 July 2019

Proposed changes to current services (if any): The service has reconfigured the service by one bedroom (room 30) no longer having access or being part of dementia care unit. Room 30 is now adjoined with a room (room 15) which is situated in the hospital-geriatric unit. There is an internal connecting door between these two rooms which are currently used by a husband and wife.

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

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Orewa Beach View Retirement Home and Hospital - Solemar provides rest home, hospital and dementia level care for up to 29 residents. The service is operated privately by two owners/directors and managed by a facility manager who is a registered nurse. The facility manager is supported by a clinical manager who is also a registered nurse.

Since the previous audit, the service has decreased the number of available dementia beds from 15 to 14 and increased the number of hospital/rest home level care beds from 14 to 15. This was implemented by inserting an internal doorway between two adjoining rooms in the care unit and sealing off one door in the dementia unit. The rooms are currently occupied by a husband and wife who are very happy with their environment. All requirements are met for the change of room use.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, and staff. The general practitioner was not available on the day of audit for interview. Residents and families spoke positively about the care provided.

This audit has identified two areas requiring improvement. One relates to advance directives which remains open from the previous audit and one relates to medication reconciliation.

Improvements have been made to adverse events management, entry to service, general practitioner reviews, initial assessments and initial care planning, referral to other health professionals, short term care planning, medication competencies, the food service,

restraint minimisation and safe practice and infection prevention and control. The service demonstrated that these areas have been fully addressed since the previous audit and are now fully attained.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination. Family members are encouraged to visit.

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

A complaints register is maintained with complaints resolved promptly and effectively. One external complaint is yet to be documented and resolved.

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.

Business and quality and risk management plans include the scope, direction, goals, values and philosophy of the organisation. Monitoring of the services provided to the owner/directors is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, 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 and were current and 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.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Prospective residents and family members are provided with information on the facility and services prior to and on entering the service.

The multidisciplinary team, including registered nurses and a general practitioner, are involving in assessing residents' needs. A podiatrist and physiotherapist are involved where required. Care plans are individualised, based on a range of information and assessments. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely stored and managed and reviewed by the general practitioner at least every three months.

Special dietary needs are catered for. Food is safely managed. Most residents or family members reported satisfaction with meals.

Safe and appropriate environment

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

There is a current building warrant of fitness. Changes made to the internal bedrooms relating to the reconfiguration of service type, meets all building requirements and does not have any effect on emergency management planning or the fire evacuation scheme. No fire cells were changed during the reconfiguration.

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. No enablers were in use at the time of audit. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Four residents were using restraint. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.

Infection prevention and control activities are facilitated by the clinical manager. Specialist infection prevention and control advice can be sought as needed. Residents are offered influenza vaccinations.

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

Surveillance is undertaken, data is analysed and trended and results are reported back to staff. Follow-up action is taken as required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	21	0	0	2	0	0
Criteria	0	49	0	0	2	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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Moderate	Nursing and care staff understood the principles and practice of informed consent. The facility's policies provide guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately in most cases using the organisation's standard consent forms and includes storage of information, medical treatment, transportation and obtaining a photograph of the resident for identification. Competent residents or family members with enduring power of attorney (EPOA), in most cases, have signed the consent forms. Records detail if the EPOA has been activated. Residents and family interviewed reported they were happy with the support that staff provided, for example, day to day conversations and different options provided. Not for resuscitation decision forms are present in the residents' notes. These have been signed by the enduring power of attorney for residents who are not competent in decision making. This was an areas previously identified as requiring improvement and remains so. From discussion, the service has implemented a new system to ensure they meet legislation and the informed consent standard requirements, but this was not fully implemented. The service has still to fully resolve this matter. There was confusion with one family who believed they were the EPOA, but on checking this with managers, it was found they were not, and confusion existed with staff regarding which family member was. The facility manager reported having difficulty in getting the required information from families.
Standard 1.1.13: Complaints	FA	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.

Management The right of the consumer to make a complaint is understood, respected, and upheld.		Complaints forms are located at the entrance to the facility. The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is 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.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated that they were well informed about the changes to their/their relative's status including when there was an incident or accident. They were regularly updated with any medical changes or outcomes from reviews. There was clear evidence in the files that contact frequency was noted on admission and a record of contacts was sighted in the files looked at time of audit. Staff knew how to contact interpreters if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, philosophy, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owner/directors showed adequate information to monitor performance is reported including quality data, resident numbers, admissions and discharges, staffing, internal audit results, water temperatures, staff appraisals, staff training and inductions, human resource issues, maintenance, complaints, corrective actions, incidents and accidents, infections, general comments, emerging risks and issues. The service is managed by a registered nurse who is the facility manager. The facility manager holds relevant qualifications and has been in the role for 18 months. They have had previous management roles in aged care over a 25-year period. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager is supported by the clinical manager who is a registered nurse. The clinical manager has worked at the facility as a registered nurse since October 2016 and moved into the current role in June 2017. Both the managers confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing clinical education and attendance at aged care management seminars relevant to the roles they hold. The service holds contracts with Waitemata District Health Board (WDHB) for aged care services at rest home and hospital level care including dementia care and respite care. All 29 residents were receiving services under the Age-

		Related Residential Care contract at the time of audit (one rest home level care, 14 hospital level care and 14 dementia care). The service also has a current Long Term Support – Chronic Health Conditions Residential contract but no residents were receiving care under this contract at the time of audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, an annual patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds, falls and pressure injuries. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly staff meetings. Staff reported their involvement in quality and risk management activities through implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. These are documented on a quality improvement plan. One quality improvement sighted related to the introduction of six monthly multidisciplinary team meetings for each resident. These meetings are minuted and showed resident and family involvement as appropriate. Resident and family satisfaction surveys are completed annually. For the most recent survey (July 2018), there was only one return received with no corrective actions required. The owner/manager and facility manager confirmed forms were given to all residents and family members. The 2019 resident satisfaction survey was ready to be sent out at the time of audit. The management team were looking at ways to gain a better return. Policies reviewed have been developed by an off-site provider and personalised to the service. They 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. The owner/director and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The service has a current hazard register and a hazardous substances register. Staff confirmed their awareness of the use of hazard identifications forms if a hazardous issue is found. The registers are reviewed annually in January by the management team.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, corrective actions are identified and followed-up in a timely manner. Adverse event data is collated, analysed and reported at monthly staff meetings and the incidents are graphed and sent in a monthly report to the owner director showing if any injury occurred, the cause of the incident, persons notified and the time and date of the incident. Incident forms are filed in individual resident's notes

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.		and a log is kept for each resident. This was an area identified for improvement in the previous audit and is now fully attained. The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one section 31 notification of a significant event made to the Ministry of Health, (19 February 2019) since the previous audit. This related to an incident between two residents. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications, such as to public health, since the previous audit.
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	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. 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 an annual performance review is undertaken. Continuing education is planned on a biannual 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. The facility manager is the internal assessor for the programme. Seven staff who work in the dementia care area have completed the required education. There are 15 staff with current first aid certificates. The clinical manager is a trained and competent registered nurse who maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance competencies to undertake interRAI.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	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. However, two care staff interviewed reported that they felt that more staff were needed for some shifts. They did not elaborate on this except to say they did not feel they should be doing dishes for residents in the dementia unit. Staff response was discussed with managers who confirmed that staff were not used to working with 100% occupancy. The only dishes washed by unit staff are plates and knives and forks which are placed in the dishwasher following meals. The owner/director stated staffing hours would be discussed at the next staff meeting and confirmed verbally that more staffing hours would be made available as required. No member of management was aware staff members had any concerns as no staffing issues had been advised. Staff did confirm that they are

and/or experienced service providers.		able to complete the work allocated to them each shift. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Residents and family interviewed had no concerns about staffing levels and said the care provided was very good. Staffing levels meet the interRAI acuity level report findings. Observations and review of six weeks of rosters confirmed adequate staff cover had been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage at the facility. There are dedicated dementia unit staff rostered across all shifts. The activities coordinator works Monday to Friday from 9am to 4pm. Kitchen staff work 7am to 1pm and 4pm to 6pm seven days a week. There is a dedicated domestic staff member from 9am to 2pm four days a week. Maintenance is undertaken by contracted companies. Laundry is part of the care workers' daily tasks.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Entry to service processes are defined. Residents requiring rest home, hospital and secure dementia care can be admitted. All residents have been appropriately assessed and only those requiring dementia level care are receiving this in the secure dementia unit. Residents in the secure dementia unit were appropriately assessed to receive this level of care by local Needs Assessment and Service Coordination. The previous area requiring improvement has been addressed.
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.	PA Moderate	The medication management policy is current and identifies required aspects of medicine management in line with legislation and current accepted practice. A system for medicine management (using an electronic system) was observed on the day of audit. The clinical manager (CM) observed demonstrated good knowledge and had a clear understanding of her role and responsibilities related to each stage of medicine management. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The CM checks medications against the prescription. All medications sighted were within current use by dates. A supply of impress medicines is available for use for hospital level residents if required. Controlled drugs are stored securely in accordance with requirements and checked by two staff (one must be a RN) when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries but not the mandatory six-monthly checks. Records displayed on the medicine room wall details the names of staff competent to check controlled drugs and

		insulin, or to administer oral medicines. This record correlates with the information in the staff files. This was an area identified for improvement in the previous audit and is now fully attained The records of the daily temperatures for the medicine fridge were within the recommended range. Good prescribing practices noted include the prescriber's electronic signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. Photographs were attached to the medicine records on all but one of the 20 residents' medicine charts reviewed. The absent photo was for a new admission. The required three-monthly GP review was consistently recorded on the applicable medicine charts. The CM advised standing orders are not used. The facility offers the flu vaccine and consent forms were sighted. Vaccines are not stored on site. There were no residents who were self-administering medications at the time of audit; however, there is a documented process regarding how this would be managed in the event of a resident being permitted to do so Medicine errors are required to be reported via the incident reporting system.
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	The food service is provided on site by two cooks who share the working week, with the assistance of supporting staff. A four-week seasonal rotating menu is used. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service food safety plan was sighted – awarded A+ (99% achieved) and dated expiry 26 September 2019. Refrigerator and freezer temperatures are monitored daily. Food is appropriately labelled and stored. The cooks have undertaken a safe food handling qualification. 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 which includes a soft diet option, morning and afternoon snacks to support residents requiring a modified diet. Evidence of resident satisfaction with meals was verified by most residents and family members interviewed, satisfaction surveys and residents' meeting minutes. Nutritional supplements are available as required / prescribed. Enteral feeding can be facilitated if required. Thickeners are available to thicken fluids for resident safety. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is food available 24 hours a day for residents in the dementia unit. This was verified by the HCA interviewed and documentation in residents' files that noted food and beverages provided to residents overnight or between

		meals. The menu was appropriate to meet the nutritional needs of the residents. There was evidence the menu had been approved and met the recognised nutritional guidelines for older people. This was an area identified for improvement in the previous audit and is now fully attained.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Long term care plans are in use and reviewed at least six monthly and now align with the interRAI information. Short term care plans are used as required and there was evidence of these being appropriately closed. Care plans evidenced service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported their participation in the development and ongoing evaluation of care plans. One standardised template is now being used for new residents and for when plans are updated. Family members interviewed confirmed residents' needs are being met. Individualised plans of care are developed for the residents within the dementia unit that covers a 24-hour period. In addition, an individualised activities plan is developed for every resident. Short term care plans have been developed for temporary needs, including related to infections, skin tears, shortness of breath, pressure injuries and other types of wounds / skin tears. The wound care plans sighted were detailed and included assessment, interventions and evaluations within the template. Family members reported they were kept up to date when the relative's needs changed and they were happy with the care and attention given to residents. Outcomes from the interRAI reassessments are undertaken in a timeframe to inform changes required to the resident's long-term care plans. This was an area identified for improvement in the previous audit and is now fully attained.
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 care provided to residents was consistent with their needs, goals and the plan of care. The focus on meeting a diverse range of resident's individualised needs was evident in-service provision. There was good communication observed between residents, family and health professionals. Residents are seen six weekly by the podiatrist if clinically necessary, or otherwise if requested by the resident / family with prior consent about charges. Care staff confirmed that care was provided as outlined in the resident's file documentation and what was discussed at handover. A range of equipment and resources was available, suited to the levels 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	The activities programme is provided by an activities co-ordinator who supports residents Monday to Friday from 10 am to 4.00 pm. The activities coordinator has completed a Health and Rehabilitation Course (Level 7) via Waiariki Institute of Technology, graduating in 2015. A social assessment and history was undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments were regularly reviewed to help formulate an activities programme that was meaningful to all the residents. The resident's activity needs are evaluated monthly and six monthly as part of the formal six-monthly care plan review. Records of attendance are maintained daily. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through day to day discussions with residents and residents' meetings. Families are supported to take their family member on outings to help attend to their cultural and spiritual choices. Residents and families interviewed confirmed residents are supported in their individual needs and find the programme provided at the facility interactive. The residents reported that they look forward to the activities of their choice and can decline to participate. A range of one on one activities occur for residents who prefer this. The residents and family expressed satisfaction in the activities options available. The activities programme for the current and next month was displayed on the notice board by the nursing station. The activities co-ordinator interviewed reported that she encourages residents to attend the planned activities. Rest home and hospital level care residents mix regularly in the dining room for meals and in the lounge and dining room when activities are occurring. Activities are planned within the dementia unit normally in the morning. Residents from the dementia unit also participate in the group activities and entertainment programmes in the main hospital area with direct supervision. Cupboards containing appropriate activities supplies were sighted. For residents with the dementia unit, a 24-hour plan includes the activities that can be undertaken with individual residents throughout the 24-hour period. There are facility cats including in the dementia unit providing distraction and companionship to some of the residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Residents' care is evaluated on each shift by caregivers and reported on designated forms. This includes maintaining behavioural monitoring charts, verifying hourly checks have been completed, monitoring fluid and food balance charts, and urinary and bowel output where applicable for individual residents. The Bristol stool chart is used to evaluate residents' bowel functions. Registered nurses normally document at least every day within the progress notes or sooner where clinically indicated. The health care assistants advise they alert the RN on duty if there is any change in the resident's condition. Evaluation of the care plan occurs at least every six months, or as residents' needs change. Where progress is

timely manner.		different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, and for residents' wounds. Where necessary ,and for unresolved problems, long term care plans are added or updated.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 03 April 2020) is publicly displayed. 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 and observation of the environment. The environment was hazard free, residents were safe and independence was promoted. The closing off of room 30 which was situated in the dementia unit and opening it as an adjoining room in the hospital-geriatric wing had the alterations made by approved contractors. The door width of the new opening allows equipment to be moved into the bedroom safely and the room has furnishings that are fit for purpose. As there is no increase in total bed numbers there are adequate facilities to meet all residents' needs. External areas were safely maintained and appropriate to the resident groups and setting.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The change in the one-bedroom status can be managed safely with existing policies and guidelines for emergency planning, preparation and response which were 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 Ministry of Civil Defence and Emergency Management recommendations for the region are met related to appropriates stocks of water and food. There are also adequate supplies of blankets, alternative cooking The current fire evacuation plan was approved by the New Zealand Fire Service on the 21 January 2014 for 29 bedrooms. Although the use for one bedroom has been changed from dementia to hospital level care no changes were required to the evacuation plan in place. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 01 April 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Emergency lighting is regularly tested. Call bells which alert staff to residents requiring assistance are available in both the bedroom which has changed from dementia to the care unit. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. No changes are required to security due to reassignment of the one room.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors. Policies and procedure are available to staff, and personal protective equipment is readily available and was observed to be used appropriately. Staff are aware not to come to work if they are sick. A sign alerts visitor not to visit if they are unwell. The goals for the Solemar infection control programme have been identified / documented and approved. On the day of audit a management plan was sighted and evidence of reporting against this was clearly documented, addressing a previous shortfall. The clinical manager is the designated IPC coordinator whose role and responsibilities are defined in a job description. Any infection issues, including monthly surveillance results, are reported to the facility manager. Residents are offered annual influenza vaccinations and are encouraged with hand hygiene and other practices to minimise the spread of infection
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for a long-term care facility with infection definitions noted. This includes urinary tract infections, fungal, eye, skin infections, such as scabies, upper and lower respiratory and gastro-intestinal infections. When an infection is identified a record of this is documented on the infection reporting form. The clinical manager reviews all infections. Surveillance data is collated monthly and analysed to identify any trends, possible aetiology, and required actions if necessary. The results of the surveillance programme are shared with staff at monthly meetings and shift handovers. Graphs are produced that identify any trends. A summary identifies the resident's name, date of infection, type of infection, results of laboratory investigations (if completed), and summary of treatment provided. Infections and any required management plans are discussed at handover, to ensure early intervention occurs. Short term care plans were developed and sighted in applicable residents' files. There have been no outbreaks of infections since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, four residents were using restraints (two with bedside rails and chair restraints, and two with bedside rails only). No residents were using enablers. Restraint is used as a last resort for safety reasons only when all alternatives have been explored. This was evident

		on review of the meeting minutes sighted, residents' files reviewed, and from interview with staff.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's (facility manager) involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator described the documented process. Family involvement is documented. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint. This was an area for improvement identified in the previous audit and is now fully attained.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care planning and interRAI reviews, six monthly restraint evaluations and at staff meetings. Residents confirmed their families are invited to be involved in the evaluation process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. The service has a process in place to identify when the next due evaluation date for restraint is to occur. This was an area identified for improvement in the previous audit and is now fully attained.

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)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Moderate	There are processes implemented to ascertain the resident’s wishes in respect to cardiopulmonary resuscitation. The choice for every patient is communicated to staff via a designated communication sheet. The ‘not for resuscitation’ forms have been updated and include an area for the general practitioner (GP) to verify competency of the resident in decision making. The resuscitation decision forms have been completed in five of five files reviewed (and then subsequent discussion with the Clinical Lead and Facility Manager identified several more examples) by family members who hold enduring power of attorney. One form was not signed by the resident or family member. The GP had noted the resident was not competent.	Persons with Enduring Power of Attorney status are signing not for resuscitation decisions for residents that are not competent to make their own decisions. There was an absence of evidential activated EPOAs on site and the facility manager advised he was not able to get these from some family members despite asking at the time of audit.	Ensure only valid advance directives are acted upon and there is evidence on site of the activated EPOAs. 90 days

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. There was evidence of the weekly stock count in red in the Controlled Drugs Register. On review there was a clear record errors/alterations in a margin or footnote. There was a record wasted/expired and unwanted controlled drugs in the Controlled Drugs Register. The required twice yearly checks were not occurring.	The mandatory completion of a six-monthly stocktake and reconciliation was not done for December 2018 and June 2019 nor any record noted the Controlled Drugs Register. On interviewing the clinical Manager and the Facility Manager they did not appear to know they had to do this nor that there were clear directions of this in the Controlled Drug Record. No system was in place to ensure this was done twice yearly as required.	Provide evidence that all legislative requirements are met and a system is in place regarding medication reconciliation of controlled drugs. 60 days

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.

No data to display

End of the report.