

# Shalom Court Auckland Incorporated - Shalom Court Rest Home

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Shalom Court Auckland Incorporated
<b>Premises audited:</b>	Shalom Court Rest Home
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 August 2019 End date: 14 August 2019
<b>Proposed changes to current services (if any):</b>	The service has reconfigured and reduced overall bed numbers from 36 to 32 beds by reducing four rest home beds
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	21

# 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
Yellow	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
Red	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

Shalom Court Rest Home and Hospital is a not-for-profit organisation that is governed by a board of management and managed by an executive officer. The service provides rest home and hospital level of care for up to 32 residents. On the day of the audit there were 21 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

A clinical operations manager is responsible for the clinical operations of the service. She is supported by a team of registered nurses and stable workforce. The residents and community visitors spoke highly of the service, including the provision of a supportive cultural and spiritual environment based on Jewish values and beliefs.

The previous audit shortfall around enabler consents remains an area for improvement.

This audit identified further improvements required around the complaints register and training.

## 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 low risk.
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Information about services provided is readily available to residents and families. The management team operate an open-door policy. There are regular resident meetings and newsletters. There is documented evidence of family notification of residents' health status. Complaints processes are implemented, and complaints and concerns acknowledged within required timeframes.

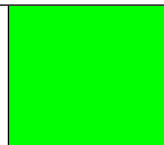
## Organisational management

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.		Some standards applicable to this service partially attained and of low risk.
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Shalom Court Rest Home and Hospital is implementing a quality and risk management system. Key components of the quality management system include (but not limited to); implementation of an internal audit schedule; annual satisfaction surveys; incidents and accidents; review of infections; review of risk; and monitoring of health and safety including hazards. Facility meeting minutes include discussion around quality data. Human resources policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice.

## 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.

A registered nurse is responsible for the provision of care and documentation at every stage of service delivery. Information gained through the initial support plans, specific assessments, discharge summaries and the care plans, guide staff in the safe delivery of care to residents. The care plans are resident-centred and evaluated every six months or earlier if required, with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three-monthly.

The event management team and volunteers coordinate the activity programme to meet the individual needs, preferences and cultural needs of the residents. Residents are encouraged to maintain community links. There are regular outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

The food service is contracted. There is a separate kosher kitchen where foods are prepared for the kosher lunches. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. The menu has been reviewed by a dietitian.

## 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.
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The building holds a current warrant of fitness. There is a reactive and planned maintenance programme.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There are policies and procedures in place that include the definition of enablers and instructions to follow in the event that restraint is required. There were two residents using enablers and no residents with restraints. Care staff receive education in restraint minimisation and safe practice.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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	13	0	2	1	0	0
Criteria	0	38	0	2	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The complaints procedure is provided to residents and relatives at entry to the service. Residents advised that they are aware of the complaint's procedure. Complaints forms and advocacy brochures were available at the main entrance. Concerns/complaints identified in meeting minutes had been discussed and addressed, however there was no complaints register in place to record the complaints. One documented internal complaint had been investigated and resolved. One HDC complaint in June 2018 had been closed out. A DHB complaint around pressure injury management resulted in a number of corrective actions which have been implemented with the exception of the STOP and Watch tool (yet to be implemented). Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The management team promotes an open-door policy. Advised that relatives are aware of the open-door policy and confirmed that the staff and management are approachable and available. There were no relatives available for interview. Residents/relatives have the opportunity to feedback on service delivery through monthly resident meetings. Residents interviewed (three rest home and two hospital) stated management have an open door. There is a resident advocate who attends resident meetings and assists residents in completing the annual survey. Quarterly newsletters are published for the FOSCA (Friends of Shalom Court Auckland) members and displayed on the resident noticeboard. Fifteen accident/incident forms reviewed for the month of June 2019 documented that relatives were informed of any incidents/accidents.</p>



conducive to effective communication.		Residents and family are informed prior to entry of the scope of services, and any payable services not covered by the agreement. An interpreter service is available if required.
<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>	FA	<p>Shalom Court Rest Home and Hospital is a faith based not-for-profit organisation and governed by a trust board.</p> <p>The service provides rest home and hospital level of care for up to 32 residents. The number of cottages for rest home level of care have been reduced from 10 to six as part of the Shalom Court goals to have more cottages available to tenant by including younger persons into the Shalom community. The main facility (Phillip House) has 14 dual purpose beds and there is a hospital wing (Albert House) of 12 beds with a separate entry and an internal corridor link between the two buildings. On the day of audit there were 21 residents (14 hospital and seven rest home including three residents in the cottages). All residents were under the age-related residential care contract. There were no respite residents.</p> <p>There has been a change in the management structure of Shalom since October 2018. The long-serving executive officer is now the Chair of the Board and the administration manager (employed since 2015) is now the executive officer (EO). A clinical operations manager - COM (registered nurse) was appointed full-time in April 2019. She has many years in aged care at management level and oversees the clinical and quality areas. The COM provides 24-hour call.</p> <p>There is a strategic business plan 2019–2022 that includes the service vision, mission and values and is reviewed regularly at the board meetings. The EO provides a monthly quality risk management report to the board. Achievements for 2018 have been the development of a gym set up beside the cottage lounge for resident use under supervision and updating the call bell system. A new Shalom governance board was formed in August 2018. Goals for 2019 include a clinical focus on end of life care, reduction of falls and improved pressure injury prevention and management. The organisation has been successful in continuing to be achieving its vision, mission and philosophy around providing care based on Jewish values and beliefs by widening Shalom's profile within the community.</p> <p>The COM has completed an orientation and attends ARC forums and cluster group meetings. She is on the ADHB steering group for palliative care and maintains a current practicing certificate. HealthCERT was notified of the change in clinical manager.</p> <p>The provider has continued to maintain its profile with the Jewish community and involve its stakeholders. Board members actively interact with residents, staff and stakeholders and take on other roles such as attending the Health &amp; Safety Committee meetings, maintaining an asset register, involvement in activities and Jewish festivities. One board member (interviewed) was on the health and safety committee. The chair of the board, executive officer and board members continue to connect with the Jewish community in a number of ways including monthly kosher lunches with guest speakers such as the local MP, the contracted food service manager on nutrition for the elderly and burial and bereavement society speaker. Shalom Court have a FOSCA (Friends of Shalom Court Auckland)</p>

		<p>membership in place. All members are invited to join in festivities and receive quarterly newsletters. There have been celebrations on site for FOSCA members including a 90th birthday, 60th wedding anniversary and honorary membership for a founding member. A working group has been formed to look at how the cottages can be utilised better to connect with younger members of the community and to provide emergency housing</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery, that have been reviewed regularly by the service. Quality risk management reports include quality data, trends and analysis that is discussed at the monthly staff meetings such as accidents/incidents. Infections, pressure injuries, audit outcomes, concerns/complaints (link 1.1.13.3), pressure injuries, equipment and resources. There are RN meetings quarterly, focused on clinical matters. Registered nurses have taken on clinical portfolios such as the wound care coordinator, infection control coordinator and weight monitoring coordinator. Staff sign an attendance record for meetings.</p> <p>Internal audits cover all areas of service and are completed as scheduled. Call bell response audits are completed monthly and call bell function is completed three monthly. Corrective actions are raised for any areas of non-compliance. An annual resident/relative survey has been completed in February 2019; however, the return rate was poor and concerns made around food services, cleaning and laundry. The service has addressed these concerns which has been fed back to the participants by the resident advocate at resident meetings.</p> <p>The Health and Safety (H&amp;S) Committee comprises of representatives across the service areas including the contracted food service and two board members (one was interviewed) who attend the three-monthly meetings. The health and safety committee review monthly accident/incident reports, hazard reports and the register. Staff have the opportunity to discuss any concerns with the representatives (one H&amp;S representative was interviewed) prior to H&amp;S meetings. Contractors receive health and safety induction. Staff have received education on emergency procedures.</p> <p>Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are in place for high falls risk residents and hip protectors worn in consultation with families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	FA	<p>There is an accident/incident policy as part of risk management and health and safety framework. Fifteen incident/accident forms (ten falls with seven unwitnessed falls, one pressure injury, three slips and two skin tears) were reviewed from June 2019. All incident forms identify timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations have been completed for unwitnessed falls and any known head injury. The next of kin have been notified for all incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical operations manager collects incident/accident forms, completes</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>investigations and implements corrective actions as required.</p> <p>The EO and clinical operations manager described situations that would require reporting to relevant authorities. There were two notifications for one resident with two pressure injuries (one stage three and one unstageable). There have been no outbreaks to report.</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>PA Low</p>	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs, and three HCAs). All files contained relevant employment documentation including completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Care staff interviewed were able to describe the orientation process and believe new staff are adequately orientated to the service. There is a performance appraisal schedule, however two of five staff files reviewed did not have annual performance appraisals completed.</p> <p>The education plan for 2018 has been completed and the 2019 education plan is being implemented, however not all mandatory requirements have been completed at least two yearly. Staff attendance at mandatory training has been below 50%. Comprehension questionnaires are completed. Staff complete competencies relevant to their roles including medication, syringe driver and male catheterisation. The physiotherapist provides safe manual handling and hoist training. Registered nurses and HCAs are supported to attend external education study days at the DHB. Three RNs and the clinical operations manager have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical operations manager is on duty Monday to Friday 9am to 5pm and on call. The EO is full-time.</p> <p>The front entrances are in separate buildings but there is an internal link between the two buildings and the cottages are separate. These have more independent rest home residents and have allocated staff 3 hours in the morning and covered by allocated care staff at other times. The call bell system links to main system.</p> <p>There is a RN on duty 24 hours that is based in Albert House – 12 beds with eight hospital level residents and provides cover for Phillip House – 14 dual purpose beds with six hospital level and four rest homes residents and the four-rest home Shalom Court cottages currently with three rest home residents.</p> <p>In Albert House there are two HCAs on the full morning shift, two on the full afternoon shift and one on the night shift. There is an HCA allocated from 7 am to 10 am in Shalom Court then is based in Albert House.</p>

		<p>In Phillip House, there are two HCAs on the full morning shift, two on the afternoon shift (one full shift and one finishing at 9 pm) and one HCA on night shift.</p> <p>There is an HCA allocated from 4 pm to 9 pm in Shalom court then is based in Albert House.</p> <p>There is an activity person four days a week.</p> <p>Residents interviewed stated there are adequate staff on duty at all times. Staff stated they feel supported by the executive officer and clinical operations manager and trust board members.</p> <p>Linen is laundered off-site. Food services staff are contracted.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for all aspects of medication management. Registered nurses and HCAs complete annual medication competencies to administer medications. Staff attend annual education. Registered nurses check the robotic rolls for regular medications and blister packs for 'as required' medications against the electronic medication charts and sign this in on the electronic medication system. There are no standing orders. There were three residents self-administering medications on the day of audit. The residents had been deemed competent to self-administer and were reviewed by the GP three monthly. An RN or medication competent healthcare assistant checks that medications have been taken as prescribed.</p> <p>There are medication rooms in both houses and a medication cupboard in the cottage nurses' station. There are two medication fridges with temperatures checked daily. The hospital house (Albert) has a hospital impress of medications that is checked weekly for stock levels and expiry dates. Eye drops are dated once opened.</p> <p>Ten medication charts were reviewed (six hospital and four rest home). Medications are reviewed by the GP at least three-monthly. All medication charts have photo identification and allergy status recorded. 'As required' medications have prescribed indications for use and outcomes are recorded on the electronic system.</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</p>	FA	<p>A contracted service provider provides all meals from the on-site kitchen. The operations manager/qualified chef oversees the food service for the site. He is supported by chefs and kitchen assistants. The head chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals except for kosher food are cooked in the on-site kitchen. There is a separate kitchen for the preparation of kosher food. All food services staff have current food safety certificates. The four weekly menu has been reviewed by a dietitian. The chef is notified of resident's dietary requirements. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are known. The chef and kitchen assistant serve meals from bain maries in the kitchenettes of each wing. Special equipment such as lipped plates are available.</p> <p>The food control plan has been verified and expires 30 January 2020. Fridge and freezer temperatures are monitored and recorded daily. End-cooked and serving food temperatures are taken and recorded. Audits are</p>

delivery.		implemented to monitor performance. The chef attends the resident meetings as required. Residents interviewed were satisfied with the meals provided.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The five resident care plans reviewed included documented interventions that meets the need of the residents. Care plans have been updated as residents' needs change. When a resident's condition changes, the RN will initiate a GP consultation. Family members are notified of any change to the resident's condition. Changes in care are documented in short-term care plans which are communicated at handovers. Short-term care plans are reviewed to monitor the residents progress and wellbeing.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence supplies. The two RNs interviewed stated there was adequate wound care products and supplies. There were wound assessments and wound management evaluations completed for five skin tears and one non-healing lesion. There was one hospital resident with one facility acquired pressure injury (unstageable). The same resident had a recently healed stage three pressure injury. There was a wound assessment, evaluation at the documented frequency and photographs that demonstrated the healing progress for the unstageable pressure injury. Wound assessments include pain assessments. The district nurse has been involved with the wound management. There was adequate pressure injury prevention equipment in place including air alternating mattresses, roho cushions, heel protectors and bed cradles.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, neurological observations, pain monitoring, repositioning and food and fluid charts. Behaviour charts are available for any residents that exhibit challenging behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are organised and run by an events management sub-committee reporting to the executive team. This committee includes a healthcare assistant who also coordinates activities four days a week. On other days of the week HCAs on duty and volunteers coordinate activities as per the programme. Daily activities are displayed on the activity boards. Activities include a variety of exercises which also include the physiotherapy volunteer and Tai Chi instructors, ball games, art therapy, book club, movies, discussions and happy hours. Residents who prefer to stay in their room have one-on-one visits for a chat.</p> <p>Community visitors include volunteers, entertainers, religious visitors and the Rabbi, singing groups, primary school children and pet therapy. There are monthly outings in a hired mobility van. Special events like birthdays, Mothers' Day, Anzac Day, Melbourne Cup and Jewish celebrations/festivals are celebrated.</p> <p>Visiting Nuns come in weekly to give communion and the priest visits as needed. The board and management provide Kiddush meals on Fridays.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the</p>

		<p>residents past hobbies and present interests, career and family. Resident files identify that the activity plan is based on this assessment. Activity plans have been evaluated six-monthly.</p> <p>Shalom Court is very community-focused and outside group and families are welcome to use the facility's communal areas and welcome to attend on-site activities.</p> <p>Resident's feedback on the activities programme at the two monthly residents' meetings. Residents interviewed commented positively on the activities and community involvement in the programme. The event management sub-committee meets annually to review the programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The care plans reviewed have been evaluated by the registered nurses six-monthly for four residents. One hospital resident had not been at the service six months. Care plans are updated when changes to care occurs. Short-term care plans for short-term needs such as infections have been evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is evidence of family members being informed of any changes to the care plan on the family communication form and in the progress notes. There are monthly emails/communication with families to update them on their relative's progress.</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>	FA	<p>The main building and rest home cottage building both hold a current warrant of fitness. There is a planned maintenance programme in place. Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. Clinical equipment has been checked, tagged and calibrated. Hot water temperatures are monitored and are within the acceptable range. A new call bell system has been installed since the last audit. Communal areas and gardens and grounds are easily accessible. There are outdoor areas with seating and shade for each wing.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly through surveillance to determine infection control activities and education needs in the facility. Data is analysed for trends and a quarterly report is provided to the infection control committee, the management, board and staff including graphs with monthly comparisons for all types of infections using the standardised definitions for infections. Preventative measures are put in place for identified trends. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>

and methods that have been specified in the infection control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Moderate</p>	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for the use of enablers and restraint. A registered nurse is the restraint coordinator with a defined job description.</p> <p>On the day of the audit, there were no residents with restraint and two residents (hospital) with enablers (bedrails). Two of two files reviewed identified enabler assessments, care plan interventions, enabler monitoring and reviewed six-monthly. Both consent forms had not been voluntarily signed by the resident. The previous finding around consent forms remains.</p> <p>Restraint and challenging behaviour education is included in the training programme.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	Complaint documentation was sighted for the HDC and DHB complaints including acknowledgement, investigation notes and corrective action plans that had been implemented, however there was no register in place therefore no record of concerns/complaints that had been raised at facility meetings.	There was no complaint register in place for 2018 and 2019 to record and monitor concerns/complaints.	<p>Ensure there is an up-to-date complaint register and complaints.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p>	PA Low	Five staff files were reviewed and contained appropriate employment documentation including completed orientations. Annual performance appraisals had been completed for three of five staff files reviewed. The training plans for 2018 and 2019 did not include all mandatory training and the records reviewed there was less	<p>(i) There is a performance appraisal schedule, however one RN and one HCA did not have an annual performance appraisal completed, and</p> <p>(ii) there has been no complaints management education or elder abuse and neglect education provided in the last two years and</p> <p>(iii) attendance at</p>	<p>(i) Ensure performance appraisals are completed as scheduled, (ii) ensure complaints management and elder abuse and neglect education in the last two years and (iii)</p>



services to consumers.		than 50% attendance at mandatory education.	mandatory education has been less than 50%.	ensure all staff attend mandatory education.  90 days
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Moderate	Consents are in place for two residents using enablers, however, the resident's relative had signed each consent form.	The two residents with enablers had not voluntarily signed the consent form and the enduring power of attorney of both residents, had not been enacted to allow the relative to sign for the enabler.	Ensure residents sign for voluntary consent of an enabler.  90 days

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

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

No data to display
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End of the report.