

Avonlea Trust Board - Avonlea Hospital and Home

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:

Legal entity:	Avonlea Charitable Trust
Premises audited:	Avonlea Hospital and Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 November 2019 End date: 22 November 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	42

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

Avonlea Hospital and Rest Home provides rest home and hospital level care for up to 50 residents. The service is operated by The Avonlea Trust Board and is managed by a facility/nurse manager and a clinical nurse leader. There have been no significant changes since the previous surveillance audit in 2018.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Waikato 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, staff, and the general practitioner (GP). All interviewees spoke positively about the care provided.

This audit identified two areas requiring improvement. These relate to floor surfaces in three bathrooms, safe storage of chemicals and the laundry, cleaners' storeroom and sluice room environments. Two ratings of continuous improvement were acknowledged in good practice and in governance.

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.

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

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

Services are provided that 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. There have been no substantiated complaints to external bodies, such as the DHB or the Office of the Health and Disability Commissioner.

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 mission statement of the organisation. Monitoring of the services provided to the governing body was 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 eight 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. These were current and are 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 integrated 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.
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Avonlea Hospital and Home liaises 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.

Residents' care plans are individualised, based on a comprehensive 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 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, enrolled nurses and care staff, 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 and 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 medium or high risk and/or unattained and of low risk.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. 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. Residents' personal laundry is undertaken onsite and bulk linen is laundered offsite by an external agency. Laundry services 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.

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.
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The service provider has implemented policies and procedures which support the minimisation of restraint. There was one enabler and 12 restraints in use at the time of this audit.

A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. 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.
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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 with data 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)
Standards	1	47	0	1	1	0	0
Criteria	2	97	0	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Avonlea Hospital and Home (Avonlea) 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.
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.	FA	Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed 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. 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 residents' files. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis.

<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 of Avonlea and their family members 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. The local advocate from an agency which provides support for older people visited the site during the audit.</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 of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns. 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</p> <p>The reviewed complaints register contained three complaints recorded since July 2018 - one of these was an outgoing complaint from the facility manager to another health provider. The other two were significant allegations from the same complainant which had been submitted to the office of the Health and Disability Commissioner (HDC), and Waikato DHB. Extensive investigations found the allegations were unsubstantiated and meetings with the DHB, the service provider and the complainant resulted in actions that have since been implemented. The records contained letters of acknowledgement and ongoing communication had occurred within acceptable timeframes. The matter is now closed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents and family members 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</p>

Consumers are informed of their rights.		and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.
<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>	FA	<p>Residents and family members of residents 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, when exchanging verbal information and during discussions with families and the GP. All residents have a private room. Residents' photos being posted on the noticeboard and on social media in the closed Facebook page, has been addressed in consent forms.</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 or activities 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>	FA	<p>There were five residents in Avonlea at the time of audit who identified as Māori. Evidence verified staff 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 cultural advisers. Residents and family members can access support from an advocacy service at Taumarunui hospital that supports Maori residents through health challenges. Observation and interviews evidenced a resident and the family were using this service to explore potential discharge planning options.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values,</p>	FA	<p>Residents and residents' family members 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</p>

And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		well residents' cultural needs are met, and this supported that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	<p>Residents and family members of residents interviewed 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 (RNs) 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>
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	<p>Avonlea is in a rural community where access to services at times is limited by the services operating hours, support services having staff shortages, limited access to resident information and resources (refer criterion 1.2.1.1) and specialist advice not being readily available. Avonlea encourages and promotes good practice with the resources available through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, and mental health services for older persons, 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. Avonlea is a member of an organisation that supports its aged care providers throughout the region by enabling the group members' access to specialist advice through education sessions, at a variety of locations.</p> <p>Avonlea is committed to maintain their knowledge of pressure area prevention and wound care management. Healing the pressure injuries of any residents admitted with pressure injuries, is a priority, and this is evidenced in residents' files (refer criterion 1.3.3). There were no residents at Avonlea at the time of audit with a pressure injury.</p>

		<p>Evidence verified that Avonlea has had no facility acquired pressure injuries since August 2016.</p> <p>Other examples of good practice observed during the audit included a commitment to maximising opportunities for residents to receive quality care despite the challenges imposed by its rural location. This was evidenced by an ongoing commitment to ensure RNs' competencies, and proactive thinking to enable residents to receive care at Avonlea which was previously not always available when required. An initiative implemented by Avonlea to address limited access of residents to phlebotomy services and reduce the potential for compromised care as a result of this, is an area recognised as one of continuous improvement. The limited access to onsite GP services, after hours pharmaceutical services, and access to specialised equipment requires anticipatory management of residents' potential needs as a consideration when planning care. This is particularly relevant when receiving residents from Waikato District Health Board (WDHB). Preplanning of residents' needs is evidenced in all aspects of care planning at Avonlea, to ensure residents can receive the care required. The facility is supported afterhours by Taumarunui hospital, to provide after-hour's medical cover, advice and pharmaceutical supplies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents of Avonlea and their 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>Interpreter services can be accessed via Taumarunui hospital when required. Staff knew how to access this information. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> <p>A regular newsletter keeps residents and their families up to date with what's going on at Avonlea. A closed Facebook page enables residents and family members to also see what's going on. Events occurring at Avonlea are posted on the Facebook page. The privacy issue around the posting of photos has been addressed. Residents have access to Wi-Fi, and can send and receive emails, or access any information desired on the internet.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, 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 from the facility manager to the trust board contained sufficient information to monitor performance and identify emerging risks and issues. The chairperson interviewed confirmed the board are kept apprised of all matters. There are plans to build a</p>

appropriate to the needs of consumers.		<p>small retirement village and to renovate some of the older rest home rooms.</p> <p>The facility is managed by a registered nurse who holds a current practicing certificate and has been in the role for 12 years. Responsibilities and accountabilities are described in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through a post with the regional chapter of the NZ Age Care Association and regular meetings with other facility managers in the Community Trust Care Aotearoa (CTCA) group. This group is continuing to add value to the nine aged related residential care facilities who are members. A rating of continuous improvement acknowledges this in criterion 1.2.1.1</p> <p>The service holds contracts with Waikato DHB for hospital-geriatric and medical, rest home, respite care, and people under 65 requiring Long Term Support-Chronic Health Conditions (LTS-CHC). On the days of audit 50 of the 42 beds were occupied. Twelve residents were assessed as requiring hospital level care, which included one person under the age of 65 and there were 30 rest home residents including one under sixty five years of age.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The organisation has a long-term arrangement with an interim facility manager who covers the facility manager's absence. The CNL role is covered by the next most senior RN. All staff and the board chair interviewed said these 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>	FA	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. A part time quality officer (QO) manages the system. This includes collation and analysis of incidents, infections and complaints, carrying out regular resident and family satisfaction surveys and internal audits, and reporting outcomes. Where areas for improvement are identified these are documented and actions are monitored for implementation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality data and benchmarking with eight other age care facilities. Quality data and information is reported and discussed at regular health and safety, infection control, restraint and quality and risk team meetings, and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The manager notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings. Review of the most recent resident and family satisfaction</p>

		<p>surveys revealed no significant issues and moderate to high satisfaction.</p> <p>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>There is a current risk management plan which is monitored by the manager and the board. The manager is familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There have been no injuries reported to Worksafe NZ since the previous audit.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed from 2019 revealed clear descriptions of the event, that the incidents were reviewed and investigated by the quality officer and the facility manager, and where necessary action plans developed. There was evidence that actions are monitored for implementation. Adverse event data is collated, analysed and reported to staff. Falls, urinary tract infections, skin tears and hospital admissions are benchmarked with the eight other facilities who belong to CTCA.</p> <p>The manager reported there have been no notifications to the Ministry of Health or the DHB and public health as per the Section 31 reporting requirements. There have been no significant events such as outbreaks, police investigations, or coroner's inquests.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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 seven 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 showed documentation of completed orientation followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. All RNs and ENs are first aid and CPR competent. Eleven of the 12 caregivers have obtained either level 3 or level 4 of the National Certificate in Health and Wellbeing.</p> <p>The clinical Leader another RN are maintaining annual competency requirements to undertake interRAI</p>

		assessments. There are two more RNs engaged in interRAI training.
<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>	FA	<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. 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, for the number of residents and their needs. There are enough staff available to replace staff when there are unplanned absences. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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 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>	FA	<p>Residents are admitted to Avonlea 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 manager or the clinical nurse leader (CNL). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. 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 WDHb's 'yellow form' 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 the local acute 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 guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide 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 member 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 medications are checked by an 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 evidenced of 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 included 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 was consistently recorded on the electronic medicine chart.</p> <p>There were no residents at Avonlea who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner, if required.</p> <p>Medication errors are reported to the RN and CNL and manager 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 available to be used if required, as at times the GP is not available to chart any</p>

		additional medication electronically. Standing orders authorisations meet standing orders guidelines.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a 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 (July-2019). Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Ruapehu District Council. A second food verification audit was undertaken in August 2019. This has resulted in an A grade certificate and an eighteen-month verification period being achieved.</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 by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>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 and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNL. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>On admission, residents of Avonlea are initially assessed using a range of nursing assessment tools, such as a 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, 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.</p> <p>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 that the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by two trained interRAI assessors on site. An additional two RNs are at present being trained. InterRAI assessments are used to inform the care plan.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>Care plans reviewed of residents at Avonlea reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>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 and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>Documentation, observations and interviews verified the care provided to residents at Avonlea was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's 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 levels of care provided and in accordance with the residents' needs. Physiotherapy services are accessed through the Taumarunui hospital if referred by the GP.</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 activities programme is provided by a diversional therapist and an activities assistant who is completing the diversional therapy training. The programme at Avonlea runs five days a week.</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 sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, visits by the local Kohanga Reo, house, beautician sessions, drives, cooking, crafts, visiting entertainers, quiz sessions and daily news updates. Residents under 65 years are enabled to access community activities of their choice. The activities programme is discussed at the residents' meetings and minutes 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 and family members of residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated each shift and reported in the progress notes. If any change is noted, it is 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 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</p>	FA	<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</p>

or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		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, as observed on the day of audit.
<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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. 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>	FA	<p>There was a current Building Warrant of Fitness (BWOFF) due to expire on 20 June 2020.</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 was 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 was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents and the staff interviewed said they know the processes they should follow if any repairs or maintenance is required, and that they were happy with the environment. Requests for repair are documented and dated in the maintenance book. Review of its contents and interview with the maintenance person confirmed that repairs are promptly and appropriately actioned.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities.</p>	PA Low	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The nine dedicated hospital rooms have ensuite bathrooms shared between two residents. Staff and visitors' toilets are designated. Locks for privacy are installed. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperature testing is carried out regularly. Review of the monitoring sheets showed safe temperatures of no higher than 45 degrees Celsius. Tempering valves are installed in water</p>

Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		<p>outlets that are accessible to residents. The boiler which provides heating and hot water is maintained and checked daily by maintenance staff.</p> <p>Repair of surfaces is needed in two bathrooms (refer to criterion 1.4.3.1)</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 setting.</p>	FA	<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>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of 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 are two dining and lounge areas, one at either end of the building. Both are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>	PA Moderate	<p>Personal laundry is undertaken on site in a designated laundry and bulk linen is laundered off site by a contracted provider. The dedicated laundry 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. There is a small designated cleaning team who have received appropriate training. Bulk chemicals were stored in a lockable shed and then decanted into appropriately labelled containers. Chemical spray bottles of 'Quell' disinfectant were not securely stored in a number of the toilets. An improvement is required in criterion 1.4.6.3. The laundry areas, cleaners' cupboard and sluice room in the main corridor are too small for purpose and the storage cupboards, surfaces and complete interiors are badly run down. Action is required to improve these service areas.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>On site fire suppression and emergency system checks are being carried out monthly by an external company. Six monthly fire evacuation drills are occurring, with the last drill on 12 June 2019. There is an approved fire evacuation scheme which did not require amendment when the new hospital wing was constructed in 2012.</p> <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for 50 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. Water storage tanks are located around the complex, and battery-operated emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</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 radiators in residents' rooms which can be individually controlled. There are additional heat pumps/air conditioners in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are 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,</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the infection control committee. The infection control programme and manual are reviewed annually.</p> <p>The manager, CNL and quality officer (QO) are designated to co-ordinate and manage infection control at</p>

and visitors. This shall be appropriate to the size and scope of the service.		<p>Avonlea and form the infection control committee. The CNL has designated responsibility for managing the clinical aspect of infection control and orientates all new staff in infection control practices. Infection control matters, including surveillance results, are reported monthly to the QO and discussed every two months at the infection control committee meeting and tabled at the staff and RN meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the groups other facilities. The organisation's trust board is informed of any IPC concern.</p> <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.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The manager has appropriate skills, knowledge and qualifications for the role. The group also has an infection control advisor in addition to the services of an expert IC advisory company. 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 CNL has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The manager, CNL and QO confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>There has been no norovirus or scabies outbreaks at Avonlea in the past thirteen years.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>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.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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, manager, outside specialists and CNL. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an increase in infections has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</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>	FA	<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 committee 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 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 with the eight other aged care providers in the CTCA group.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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 her role and responsibilities.</p> <p>On the day of audit, 13 residents were using restraints and one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of</p>

		the restraint approval group minutes, files reviewed, and from interview with staff.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group, made up of the manager, CNL, another RN and the QO, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The CNL/restraint coordinator undertakes the initial assessment with input from the resident's family/whānau/EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and perimeter guard mattresses).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p>

		Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.
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 plan and interRAI reviews, and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint 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.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes two-monthly reviews of all restraint use which includes all the requirements of this Standard. The meeting minutes and reports on individual use of restraint use are shared at quality and staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the CNL and manager confirmed that efforts to reduce the use of restraint is continuing.

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>Inspection of all toilet and bathroom areas revealed holes and gaps in the vinyl floor and where the floor meets the lower wall surfaces in E wing, and in the ‘big’ corridor bathrooms. These bathrooms are shared by the group of residents and for mobility impaired residents who need the bigger bathroom. Maintaining a high level of hygiene in these wet areas is compromised by the surface gaps.</p> <p>These areas had been scheduled for refurbishment but the plans for interior redesign has held up repair work. The facility manager and board chairperson concurred that resurfacing of these areas needed to go ahead as the interior redesign project had not been fully scoped and was most likely not due to start in the next two years.</p>	The floor and lower wall surfaces in twobathrooms are degraded which poses a risk of cross infection.	<p>Ensure that all surfaces in wet areas are intact.</p> <p>180 days</p>
Criterion 1.4.6.3	PA	Bottles of disinfectant and other cleaning products were left in a resident’s	Cleaning	Ensure all

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	Moderate	<p>ensuite bathroom, and spray bottles of Quell disinfectant were found in two of the residents' toilets. Staff are instructed to disinfect toilets each time a resident uses these but had no secure areas to store the chemicals between uses. The bottles were removed on the day.</p> <p>The designated laundry areas, cleaners' room and the original sluice room are in need of refurbishment. The laundry is very small and although this is only used for laundering residents' clothes, the cupboards, sink, floor and wall surfaces are badly degraded. Folding, ironing and labelling of personal items is carried out in a room opposite the laundry which is not much bigger than a cupboard. Staff said the environment gets very hot in the summer. The cleaners' room is also too small for purpose, and staff cannot move freely when the trolley is stored in there. The floor and wall surfaces in this room are also seriously degraded, which compromises the ability to keep the area clean. There is a small opening window, but better ventilation is required because of the chemicals stored in there.</p> <p>The interior and degraded surfaces in the 'original' sluice room compromises effective infection control. Bedpans and urinals are stored on wooden shelves, the under-sink cupboards are not secure and the benchtop surface is not sterile. The dimensions of the room and positioning of the sanitizer impede direct access to the sluice.</p>	<p>chemicals were not being stored securely</p> <p>The interior environments of the laundry, cleaners' room and the original sluice room require refurbishment.</p>	<p>chemicals are stored safely and not accessible to residents or visitors.</p> <p>Develop a refurbishment plan for the original sluice room, cleaners' storeroom and laundry areas. Seek board approval for upgrade of these areas and implement if possible within 12 months.</p> <p>90 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>A review of resident care in June 2018, identified an ongoing problem of residents being unable to access the requested blood tests within a timely manner. This was as a result of the local laboratory having ongoing limited staffing resources. In the six months January 2017 to June 2018, 67 residents required urgent blood tests within 24 hours, and the laboratory was only able to attend onsite as required, for three of those. The remaining 63 took three days to have these attended to. This generally was achieved by having to take residents, who were often sick, off site to the laboratory.</p> <p>An initiative was implemented to train the RNs at Avonlea in phlebotomy, and to purchase testing equipment to enable one of the required tests often required, to be completed on site. The initiative was implemented in July 2018. The RNs were trained by the laboratory staff in phlebotomy and assessed to ensure</p>	The services offered by Avonlea have been expanded to address the limited availability of blood testing services in the area required to meet residents' needs.

		<p>their competency. Blood samples are then delivered to the laboratory for testing. Competency assessments are carried out yearly by the laboratory. A monitor was purchased to detect a resident's blood clotting time, by just requiring a finger prick blood sample. Three residents with dementia, now remain in a familiar environment and have the required blood monitoring performed by someone familiar in a less imposing manner.</p> <p>An evaluation of the initiative in June 2019, identified all requests for blood tests and coagulation tests were attended to onsite at Avonlea on the day requested.</p>	
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The CTCA is a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations.</p> <p>Members of the CTCA group have experienced significant improvements in their governance and business operations which leads to improving resident care. The sharing of innovative ideas and strategies across the facilities, cost savings in bulk purchasing for goods, power and insurance, same banking and increased borrowing capacity, shared staff and board training and peer support for RNs and managers is of benefit to all, as evidenced in the reports generated across the group and through interviews.</p> <p>This group has elected its own governance subcommittee. Meetings between the DHB and the chairperson of the governance committee resulted in Avonlea piloting the use of a DHB based patient information portal. This allowed Avonlea's registered staff to immediately access information about their residents who had been seen by medical staff at Waikato Hospital. This enables staff to initiate prescribed treatments and/or plan and arrange follow up appointments ordered by specialists and keep family informed about progress.</p>	<p>Residents and their families are immediately updated and informed about outcomes from specialist appointments at Waikato Hospital as a result of Avonlea being able to access the DHB based patient information portal. This has significantly reduced unnecessary delays in beginning treatment or ordering further tests and follow up. The DHB have evaluated this as effective and authorised access is continuing.</p> <p>The collegiality being built between all governing bodies and facility managers in the CTCA group is providing valuable peer support, generating innovation and ideas and providing strategic direction for all members. One of the members is venturing into construction of a dementia unit as a direct result of the information and support provided within the group. This was evidenced by review of the group reports, interviews with a board member and the manager.</p> <p>The group are regularly holding shared training sessions for care staff to attend which is cost efficient, provides more training opportunities and has fostered the participants' commitment to progress and achieve higher levels of education. Eleven of the 12 care staff employed at Avonlea have now achieved Level 3 and higher of the National Certificate in Health and Wellbeing. Two years</p>

			<p>ago, less than half the staff had started on a career pathway. The RNs and diversional therapists interviewed were enthusiastic and said they benefited immensely through giving and receiving peer support, as they are all regionally isolated and not able to access outside support easily.</p> <p>The cost benefits for the group are measured in savings gained from group discounts for insurance, bank fees, power supply and bulk purchasing for essential supplies such as continence products, chemicals and food supplies.</p>
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End of the report.