

Forrest Hill Continuing Care Limited - Forrest Hill Home and Hospital

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:	Forrest Hill Continuing Care Limited	
Premises audited:	Forrest Hill Home and Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 28 January 2020	End date: 29 January 2020
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:	71	



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

Forrest Hill Home and Hospital provides rest home and hospital care for up to 75 residents. The service is privately operated and managed by a general manager with assistance from a clinical manager, both hold current annual practising certificates. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit has resulted in two continuous improvement ratings in relation to good practice and the activities programme. One area requiring improvement was identified in relation to information management.

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

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure residents and family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There was no evidence of abuse, neglect or discrimination.

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

Residents and family members interviewed spoke very positively about the comfortable, relaxed environment and the care and support provided.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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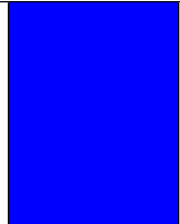
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing education 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 persons.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Residents are assessed prior to entry to the service to establish the level of care required. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service is provided onsite and caters for residents' needs. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place.

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 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 provided shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are fully trained in chemical management, emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is well 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 organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and three restraints were in use at the time of 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 management system is in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented.

Infection data is collated monthly, analysed and reported on during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	47	0	1	0	0	0
Criteria	2	98	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Forrest Hill Home and Hospital has policies and procedures to meet their obligation 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 and in ongoing training as verified in the training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p>

<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>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons. The acting clinical coordinator and staff provided examples of the involvement of advocacy services in relation to residents' care.</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. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 12 complaints have been received over the past year and that actions taken, through to an agreed resolution are clearly documented within the timeframes required. Action plans showed any required follow-up and improvements have been made where possible. The general manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are needed. One complaint/case is before the Coroner (letter dated 9 November 2019) since the previous audit and the general manager is awaiting confirmation of any outcome.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board contractual requirements.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home level of care, able to move freely into the surrounding secure gardens and in and out of the facility with no restrictions. Records sampled 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>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The acting clinical coordinator reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. The acting clinical coordinator reported that assessments and care plans would document any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as outlined in the policy. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. There were no residents who identified as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	<p>FA</p>	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct.</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The acting clinical coordinator stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service encourages and promotes good practice through ongoing professional development of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Policies and procedures are linked to evidence-based practice.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family members stated they were kept well informed about any changes to their relative's health 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The annual business plan and quality policy clearly identifies the purpose, values, scope, direction and goals of the organisation. The goals for the business plan are documented and were reviewed for 2020. The documents described annual and longer-term objectives and the associated operational plans. The general manager interviewed provides regular reports to the owner/directors. Bed status, emerging risks and any issues are discussed with one of two director's weekly.</p> <p>The service is managed by the general manager who holds relevant qualification (health professional qualification) and has been in this role for three years. The general manager (GM) is also responsible for another facility owned by the same organisation. The general manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The general manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency by attending study days at the DHB and gerontology courses and conferences as per the training records. The GM is supported by clinical managers at both facilities and the registered nurses.</p>

		The service holds contracts with the DHB for provision of rest home level care, hospital level care and respite care. Seventy-one (71) residents were receiving services under the contract; twenty-two (22) rest home level care, forty-eight (48) hospital level care and one (1) receiving respite care at the time of the audit. The total beds available are 75 dual purpose beds.
<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	When the general manager is absent, the clinical manager carries out all the required duties under delegated authority. The director is also available as necessary. During absence of key clinical staff, the clinical management is overseen by the GM who is a registered nurse and is experienced in the sector and able to take responsibility for any clinical issues that may arise. The clinical manager was on annual leave and a senior registered nurse was covering in that role on the days of the audit. Staff interviewed reported the current arrangements work well.
<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 a quality and risk system. The risk management plan dated November 2019 to November 2020 was reviewed and reflected the principles of continuous improvement and was understood by staff. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey (the last annual resident survey was completed November 2019 and a staff survey October 2019), monitoring of outcomes, clinical incidents including any infections and restraint minimisation and safe practice.</p> <p>Terms of reference and meeting minutes were reviewed and confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported at the monthly registered nurse meetings and quality and staff meetings held monthly. Minutes reviewed included discussion on any pressure injuries, restraint use, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through these meetings. The GM stated relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Results of the above surveys showed satisfaction with service provision and the staff survey (only 10 of 50 staff returned the survey) were satisfied with their roles and working conditions.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements and were current. The document control system ensures a systematic and regular review process occurs, referencing of relevant sources, approval and distribution. A process is also in place for the removal of obsolete documents. Staff are updated on new policies or changes to policies through the shift handovers and staff meetings.</p>

		<p>The GM described the processes for the identification, monitoring and reporting of any risks and development of mitigation strategies. The hazard risk register was current and any identified risks are discussed at the three-monthly staff meetings. The GM interviewed was aware of the Health and Safety at Work Act (2015) requirements and has implemented all requirements.</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. All incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner by the GM. All incidents are collated monthly, analysed and summarised. Falls are documented under witnessed falls and unwitnessed falls and other incidents under appropriate headings, such as skin tears, pressure injuries, staff injuries and residents that 'go missing'. The summaries are presented at the three-monthly quality/staff meetings and meeting minutes showed discussion in relation to any trends, action plans and improvement made are documented.</p> <p>Policy and procedures described essential notification reporting requirements and the GM was fully informed and described the essential notification reporting requirements. One coroner's case has been reported to HealthCERT on a Section 31 Notice since the previous audit. The last correspondence was received 09 November 2019 and the GM is awaiting the outcome.</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>Policies and procedures were in line with good employment practice and relevant legislation and guide human resource management processes. Position descriptions reviewed were current and defined and the key tasks and accountabilities for the various roles. The employment process includes refer checks, police vetting, immigration status and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff induction/orientation includes all necessary components relevant to the role. Staff interviewed reported that the orientation process prepared them well for their role and included support from another staff member (buddy system) through their initial orientation period. Staff records reviewed showed documentation of completed orientation (an orientation checklist is in each staff record) inclusive of hand hygiene competencies and an appraisal completed after a three-month period and annually thereafter. All other competencies required are completed within three months of employment for care staff and sooner for registered nurses. Competencies are completed in written and practical sessions.</p> <p>Continuing education is planned annually. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand</p>

		<p>Qualification authority education programme to meet the requirements of the provider's agreement with the DHB. There is a registered nurse who is the quality coordinator/educator for this service and is responsible for all staff education provided, competencies being completed and educational records being maintained. Education records reviewed demonstrated completion of the required training. Registered nurses reported at interview that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review of competencies. Appraisals were current for all staff.</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>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The policy identifies that the staffing levels reflect the number and mix of residents, acuity of residents, residents' care levels, layout and design of the facility, staff skills and experience. The appropriate skill mix was reflected on the two weekly rosters sighted. The GM is responsible to ensure that each shift is filled by staff with the appropriate experience and skills. Junior staff are always supervised by a senior staff member and do not work by themselves until deemed competent. Staff working in senior positions have the necessary qualifications and competence to do so.</p> <p>There is also a compliment of auxiliary staff rostered on during the day time hours. Staff levels observed reflected residents' assessed needs. In cases of emergencies, major outbreaks, or when a large number of staff are unable to fill their duties, appropriate replacements are sought. The last four weeks rosters were reviewed. Care staff work across all areas of service delivery. Staff are allocated at the time of handover. Staff interviewed prefer this system as they get to know all residents and understand their individual needs. The facility adjusts staffing levels to meet the changing needs of residents. Staff are always replaced for unexpected events such as sickness and planned annual leave. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) registered nurse cover.</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>	PA Low	<p>A resident register is maintained of all current and past residents. Resident individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GPs and allied health service provider notes.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. 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>

		An improvement is required to ensure progress notes have time of entry by the writer.
<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>The entry to service policy includes all the required aspects on the management of enquiries and entry. Forest Hill Home and Hospital welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the residents, family/whanau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</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>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>The medication management policy for Forest Hill Home and Hospital identifies all aspects of medicine management in line with the Medicines Care Guides for Residential Aged Care. Indications for use were noted on 'as required' (PRN) medications, allergies were clearly indicated, and clients' photos were current. Administration records were maintained, and drug incident forms completed in the event of any drug errors. Three monthly medication reviews were completed.</p> <p>Documentation for administered medication was sighted. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service. Medicines are checked against the prescription.</p> <p>There were no residents self-administering medications at the time of the audit. Self-administration medication policies and procedures are in place if required.</p> <p>Weekly and six-monthly controlled drug stock take were conducted and evidence of this was sighted.</p> <p>Medication audit was conducted, and corrective actions have been acted on.</p> <p>Regular temperature checks for the medication room and medication fridges were conducted and maintained. No vaccines are stored on-site.</p>

		All staff who administer medication have current medication administration competencies. Two RNs in their respective wings were observed administering medication correctly.
<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>There is an approved food plan for the service which expires 25 March 2020. Meals are prepared on site and served in the allocated dining rooms. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.</p> <p>Residents' food preferences are developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents as and when required. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</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	The acting clinical manager reported that all residents who are declined entry are noted on the resident refusal entry form. Reasons for refusal could be serious mental health issues, assessed for level of care that is not provided by the service and the potential resident displays behaviour that could disrupt other residents. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Residents have their level of care identified through needs assessment by the assessment agency. Initial nursing assessments are completed within the required time frame on admission while residents' care plans and interRAI are completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents and other health team members as appropriate. Additional assessments are completed according to the needs of the residents; these included pains, behavioural, falls risk, nutritional requirements, continence, skin and pressure assessments. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment

		process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whanau and residents interviewed confirmed they are involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and GP.</p>
<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>Interventions are adequate to address the identified needs in the care plans. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.</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>	CI	<p>The activities programme has gained a continuous improvement rating. The activities provided are individualised to be meaningful for residents under 65, rest home and hospital level of care.</p> <p>The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with a number of community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.</p> <p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A residents' activities profile is completed within two weeks of admission in consultation with the family and residents where able. The activities are conducted by the lifestyle manager who is a qualified diversional therapist (DT) and activities coordinator covering both the rest home and hospital. There are other experienced care staff currently studying the diversional therapy course who fill in on weekends or when regular activities staff are away.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses and care staff complete progress notes daily for residents assessed as requiring hospital level of care, weekly for residents assessed as rest home level of care and as necessary, if required (refer criterion 1.2.9.9). All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. A waste management contractor is contracted to manage all waste. The local council recycling service is utilised appropriately. Material data sheets are available in the laundry and accessible to staff. No products are decanted other than under the manufacturer's instructions for cleaning, kitchen and laundry services.</p> <p>There is provision and availability of protective clothing which was observed in the bathrooms and throughout the service areas. Staff interviewed were aware of using protective clothing as required for different tasks for protection.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness was displayed that expires 14 July 2020. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a maintenance programme in place for the building, equipment and any upgrading or renovations. Testing and tagging of essential equipment were current and on the maintenance plan.</p> <p>There are external areas available that are safely maintained and are appropriate for the resident group. The environment is conducive to the range of activities undertaken. Residents are protected from risk associated with being outside.</p> <p>Residents interviewed confirmed that the accommodation met their needs and were observed to move freely around the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The hospital wing is located near reception and all rooms have a handbasin and shared toilet and shower between every two rooms. Only three rooms do not have a shower/toilet facility however a shared shower/toilet is in close proximity to these individual rooms. The recent new purpose-built wing / addition to the home and hospital as evidenced in the partial provisional audit, has thirteen (13) individual residents' rooms each with their own shower/toilet. All these bathrooms are large in size. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' independence and safety. Wing 6 has a separate sluice room which was sighted.</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>	<p>FA</p>	<p>There is adequate personal space provided to allow residents and staff to move around within their rooms safely. All bedrooms provide single accommodation except for one double room which only has one resident residing in this room currently. Residents spoke positively about their accommodation. Rooms are personalised with furnishing, photographs and other personal items. There is adequate storage for walkers, wheelchairs and total mobility scooters if needed.</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</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. A library area was sighted and accessible for residents. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enable residents to mobilise freely.</p>

relaxation, activity, and dining needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on-site by designated staff. Resident's personal items are also laundered on site or by family members if requested. Residents interviewed reported the laundry is manged well and their clothes are returned in a timely manner. The laundry staff member on duty interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. The maintenance staff member also interviewed had purchased two new commercial washing machines for the facility in 2019 and both of these resources are serviced annually in April. The lint is also removed regularly from the clothes dryer as part of the maintenance programme.</p> <p>Chemical training has been provided for all kitchen, laundry and cleaning staff which was reviewed in the staff training records. Material safety data sheets are displayed in all service areas for each product used.</p> <p>There is a designated cleaning team who have received appropriate training. All chemicals are stored in a locked cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme reviewed.</p> <p>The service demonstrated their commitment to the principals of health and safety and to providing healthy and safe work environments.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides and 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 current fire evacuation plan was approved by the New Zealand Fire Service on the 22 July 2019. A trial evacuation occurs six monthly with a copy sent to the New Zealand Fire Service, the most recent being on the 19 November 2019. 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 barbeques were sighted and meet the requirements for the total number of residents. Water storage tanks are located around the complex. An additional water tank was installed under the deck area of the most recent addition to the building. There is no generator on site. Emergency lighting exists and is checked regularly.</p> <p>Call pagers alert staff to residents requiring assistance. Staff have pagers which work effectively. Emergency bells are also in place. Call system audits are completed on a regular basis and residents and families reported that staff promptly respond to call bells.</p>

		Appropriate security arrangements are in place. Doors are locked by staff at 8pm in summer and 6.30pm in the winter. A secure environment was observed. All residents/family/staff were aware of risks associated with the closeness of the facility to two road frontages (refer to restraint minimisation and safe practice standard requirements 2.1.1).
<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>	FA	<p>All residents' rooms and communal areas have opening external windows. Only one room in the new wing has a sky light fire window (special fire proof glazing) due to the design of the room. Electric panel heaters are installed in all individual rooms and hallways and underfloor heating exists. The heating/air-conditioning unit installed in the new building has a system in place to replace the air five times per hour. Two heat pumps have been approved for the new build main dining and lounge room (to be installed before the winter). On visual inspection 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, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted.</p> <p>The registered nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported at monthly staff and management meetings.</p> <p>The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p> <p>There is information that cover aspects of infection control for family/whanau and if they are unwell and it is recommended that they do not visit the service. During higher risk times of community infections and winter months, notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service. Hand washing and sanitiser dispensers were readily available around the facility.</p> <p>No infection outbreak has been reported since the previous audit.</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 infection prevention and control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information is accessed from an external infection control agency, the infection control team at the DHB and the GPs as required. The infection coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</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 provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were updated and include 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. Staff interviewed verified knowledge of infection control policies and practices.</p>
<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>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The infection control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets current best practice and guidelines. External contact resources included the GPs, laboratories and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	FA	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented.</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Information is sent to the external consultant for benchmarking. The infection control benchmarking is completed every three months by the externally contracted consultant. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service was aiming for a restraint free environment but does have policy and procedures to guide staff in the safe use of restraint should this be required. The restraint co-ordinator discussed the alternative to restraint and was clear about the process should anyone require restraint. This was confirmed with interviews with staff. The policy identified that the use of enablers is voluntary and the least restrictive option to meet the needs of the residents to promote independence and safety. There are six residents using enablers at the time of the audit and three restraints were in use.</p> <p>The service operates under an environmental restraint for the security and safety of residents due to the facility being located on two road frontages. The home has a locked door at the entrance to the hospital wing from the reception area. A bottom is signed posted to push to release this locked door as needed. Consent is obtained on admission and the families/residents interviewed were clear about this procedure and its rationale.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the general practitioner and a registered nurse or the restraint co-ordinator are responsible for the approval of the use of restraints and the restraint processes, as defined in policy. It was evident from review of restraint approval group meetings, review of residents' records and interview with the restraint co-ordinator that there were 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/whanau/EPOA involvement in the decision making as is required by the organisation's policies and procedures was on record in each case. Use of restraint or an enabler is included in the interRAI and care planning process and documented in 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</p>	<p>FA</p>	<p>Assessments for the use of restraint were clearly documented and included all requirements of the restraint minimisation and safe practice standard. The initial assessment is undertaken by a registered nurse with the restraint coordinator's involvement and input from the resident's family/whanau/EPOA. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner has involvement in the final decision on the safety of the use of the restraint.</p>

relation to use of restraint.		The assessment process identified the underlying aetiology, 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.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The use of restraints is actively minimised and the restraint coordinator described the alternatives to restraints which are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and suitable alternatives, such as the use of sensor mats and low beds, before use of a restraint is implemented. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records contained the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. This is included in the resident's care plan and monitoring forms reviewed recorded that this had occurred as required.</p> <p>A restraint register is maintained and was reviewed. This is 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> <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 interviewed understand that the use of restraint is to be minimised and how to maintain safe use was confirmed.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Review of residents' records evidenced the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews six monthly and three monthly by the restraint coordinator and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation includes all requirements of the Standard including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and if documentation was fully completed as required.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of	FA	The restraint team undertakes a six-monthly review of all restraint use which includes all the requirements of this standard. Six monthly restraint meetings and reports completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether any

<p>their use of restraint.</p>		<p>alternatives to restraint have been considered, the effectiveness of the restraint 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 provided and any processes are implemented if indicated. Data reviewed, minutes and interviews with staff, the general manager, the GP and the restraint coordinator (who has been in this role for five years) confirmed that the use of restraint has been reduced in the last three years significantly.</p>
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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 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	<p>Written records were legible with the name and designation of the person making the entry identifiable. Some entries by staff in residents' progress notes had no time of entry.</p>	<p>Some documented progress notes had no time of entry.</p>	<p>Ensure residents progress notes has time of entry indicated to meet the requirements of the standards.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The organisation identified that a number of patients were required to remain in the public hospital while undergoing a long-term antibiotic treatment via a peripherally inserted central catheter (PICC) line. All this was done to provide person centred care in a consistent manner under a homely safe environment. Forrest Hill Home and Hospital in conjunction with the local district health board embarked on an outpatient intravenous antibiotic (OPIVA) Aged Residential Care Programme where a total 10 RNs were trained. The training was designed to provide RNs with the essential knowledge required to safely and competently care for patients on the OPIVA programme.</p> <p>This resulted in the local district health board discharging any patient with a PICC line to the service. The programme has had a positive effect on the</p>	<p>The programme exceeds the requirements of this standard and demonstrates improved processes for service delivery. Staff received in depth training and professional development in a new field of primary care. The trained RNs were competent in providing required care for patients under the OPIVA programme. They were supported by the local district health board team. All 10 patients successfully completed the programme with no complications reported. Treatment was appropriate to their needs. The treatment was provided in a private allocated room. The facility manager reported that all patients were satisfied with care provided.</p>

		<p>patients' treatment and recovery needs. Treated in a friendly and homely environment with successful outcomes. Furthermore, this has significantly reduced the costs to the district health board and freed up beds for more urgent cases. In interviews the RNs expressed satisfaction with the programme and more so the positive outcomes for residents involved. In 2019 a total 10 patients used the service with an average stay in the service of one month.</p>	
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in from Monday to Sunday. Residents, under 65 years of age, rest home and hospital level of care are assessed and invited to specific activities that are appropriate for their level of ability and these are used to facilitate emotional and physical wellbeing. The activities can either be group activities or one on one under the guidance of the DT and activities coordinator. All the activities evidenced documented evaluations on the resident's participation and the outcomes that residents are achieving from these. Through the evaluation of existing activities, the service has implemented further stimulating activities to gauge interest and capture those still reluctant to join in.</p> <p>The service introduced music therapy for several residents with behavioural issues and significant cognitive decline. This was through use of earphones and MP3 players. The music was downloaded according to each resident's preference for music in consultation with family/whanau. Outcome measures of the music therapy were through the following responses; cognitive wellbeing, stress reduction and behaviour modification. All six residents trialled were observed to generate positive responses such as humming, tapping, smiling, nodding and felt relaxed</p>	<p>The achievement of the quality improvement projects related to the activities programmes and implementation of the music therapy programme is rated beyond the expected full attainment. With this project, there has been a documented review process which included the analysis and reporting of findings. The introducing of the music therapy programme activities and the evaluation of the existing programme included documenting actions to make improvements. This has resulted in increased staff knowledge, confidence in engaging residents in various activities. Attendance numbers increased as a result of developing and increasing residents' skills and participation in meaningful activities. Daily exercises were beneficial in improving muscle tone and reducing falls. Family/whanau satisfaction survey results confirmed satisfaction with the activities programme. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>

		reducing behavioural problems. The activities are varied, unique and provided seven days a week with trained personnel. Attendance numbers significantly increased due to a variety of activities introduced. Daily exercises resulted in improved muscle tone thereby reducing falls and boredom.	
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End of the report.