

T M & D L Beer Holdings Limited - Kenwyn Rest Home & 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	TM & DL Beer Holdings Limited
Premises audited:	Kenwyn Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 March 2020 End date: 3 March 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:	56

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

General overview of the audit

Kenwyn Rest Home and Hospital is privately owned and operated. The service provides care for up to 59 residents requiring hospital, rest home and dementia level care. On the day of the audit, there were 56 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

The service is overseen by a clinical operations manager/registered nurse who has been in this leadership role for eight years. The clinical operations manager is supported by a general manager. Residents, family and the GP interviewed spoke positively about the service provided.

There are two areas of continuous improvement awarded around good practice and staff retention.

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.

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family reported communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

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.

Services are planned and coordinated and are appropriate to the needs of the residents. The clinical operations manager/ and the general manager are responsible for the day-to-day operations of the care facility. The clinical operations manager is supported by a registered nurse (second in charge) and team of care staff. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place

for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

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.
--	--	--

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed are reviewed at least six monthly. Resident files include medical notes by the nurse practitioner and contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines and complete annual medication competencies. Medication charts are reviewed three monthly by the general practitioner or nurse practitioner.

The activities team coordinate and implement the activity programme. An activity coordinator and care staff coordinate activities in the dementia care unit. Activities offered meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents interviewed were satisfied with the activities offered.

All meals and baking are done on site by cooks with assistance from kitchenhands. The menu has been reviewed by a dietitian. Resident preferences and dislikes are accommodated. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

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

There is a current building warrant of fitness. Chemicals are stored safely throughout the facility. There is one double room, with the remainder all single rooms. Some rooms have ensuites and there are communal toilets and bathrooms. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate, and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit there were four residents using restraint and one resident using an enabler.

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.

The clinical operations manager undertakes infection control activities. There are infection control policies and procedures to guide practice. There is an infection control programme that is reviewed annually, and staff receive ongoing training. Infection control practices are monitored through the internal audit programme. 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	1	49	0	0	0	0	0
Criteria	2	99	0	0	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>The Code of Health and Disability Consumers' Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Two managers (one general manager and one clinical operations manager/registered nurse) and fourteen staff (six caregivers, two registered nurses (RNs), one maintenance, two activities staff, one cook, one kitchen assistant and one laundry staff) interviewed confirmed their understanding of the Code and were able to give examples of how the Code is applicable to their job role and responsibilities. Staff receive training about the Code during their induction to the service. This training continues through the staff education and training programme.</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>Informed consent processes are discussed with residents and families on admission. Written general consents are signed as part of the admission. Specific consents reviewed had been signed by resident/relatives for procedures such as photographs. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care.</p> <p>Resuscitation status is signed by the competent resident or where the resident is deemed incompetent the GP makes a medically indicated resuscitation decision in discussion with the EPOA. Advance care plans and enduring power of attorney (EPOA) where available are held in the resident file.</p>

		Discussions with family members identified that the service actively involves them in decisions that affect their relative's life.
<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>HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. A resident advocate is appointed to the service with contact details posted in a visible location. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Regular education is provided to staff by the local HDC advocacy service.</p> <p>Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.</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>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with the rest home level residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Examples include RSA, van outings and church services. Members from the Lions Club and the Rotary Club come to visit residents. A family day is organised once per year. Each year, the community is invited to the facility to listen to speakers discussing Alzheimer's and dementia to inform. Local entertainers regularly visit the facility. A fortnightly programme involves the local kindergarten where children visit and do activities with residents.</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 procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A register of all complaints received is maintained. Two complaints were received in 2019 and one in 2020 (year to date) that has been lodged with HDC. This complaint, around a resident's care, was received 13 January 2020 and acknowledged with HDC on 14 January 2020. It has been investigated with documentation sent back to HDC on 21 February 2020. The facility is awaiting a response from HDC.</p> <p>There were no concerns expressed by the DHB prior to this audit.</p> <p>Documentation including follow-up letters and resolution demonstrate that complaints are well-managed. Discussions with residents and families/whānau confirmed they were provided with</p>

		information on the complaints process and remarked that any concerns or issues they had were addressed promptly.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The clinical operations manager, general manager (GM) and/or RN staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the three-monthly resident/family meetings. All four residents (two rest home, two hospital) and five family (three dementia, two rest home) interviewed reported that the residents' rights were being upheld by the service.</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>	FA	<p>The residents' personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.</p> <p>The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that the residents' privacy is respected. There is one double room that is shared between two (hospital level) residents with evidence of consent gained from families and residents. Privacy curtains are in place.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected.</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>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Links are established with Tui Pa marae. Resident rooms are blessed following a death. Cultural values and beliefs that are identified are documented in the resident's care plan.</p> <p>Staff interviews includes questions regarding Māori values and beliefs and links to the Treaty of Waitangi. Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service (January 2020). The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There were two residents living</p>

		at the facility that identified as Māori and Cook Island Māori during the audit. One family member/whānau was interviewed and reported that staff are very respectful of residents including respect for their culture. Staff reported that they speak in te reo Māori with the residents who speak te reo and that the residents really enjoy this means of communication.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all eight care plans reviewed. Information is collected through the resident and their family/whānau to identify specific cultural values and identify ways to apply these principles. Residents and family interviewed confirmed they were involved in developing the resident's plan of care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Good practice was evident. A registered nurse is on site 24 hours a day, 7 days a week. A nurse practitioner (NP) or GP visit the facility once a week. Residents are reviewed by the NP every three months at a minimum. GP visits are for more complex situations. The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Support is also provided through Hospice New Zealand. Physiotherapy services are available on an as needed basis through a local provider and/or the DHB community physiotherapist. The clinical operations manager has completed a post graduate diploma in health science advanced nursing, specialising in common and chronic health conditions (June 2016). She was approved to prescribe in primary health and speciality teams in July 2019. Outcomes achieved as a result of this have resulted in a rating of continuous improvement. A van is on site for regular outings. Residents and family/whānau interviewed reported that they are

		<p>either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed high levels of satisfaction with the services received (sample 16 residents/families).</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>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. A family communication sheet is held in the front of the residents' files. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event. A quality initiative has included providing families with an overall picture of the resident's health and well-being status every three months (vs. discussing medications/medical conditions only following the three-monthly NP review). This information is then linked to the resident's care plan. During the audit one resident was observed speaking to her son in Australia via the internet (Skype) with assistance provided from staff.</p> <p>An interpreter service is available and accessible if required through the citizens' advice bureau. Families and staff are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Kenwyn Rest Home provides care for up to 59 residents at rest home, hospital (geriatric and medical) and dementia levels of care. The rest home and hospital have 40 beds (8 dual-purpose, 12 hospital and the remaining 20 rest home level). The dementia unit provides care for up to 19 residents. On the day of the audit, there were 17 residents in the dementia unit, 14 hospital residents and 25 rest home residents. Two residents (one dementia, one rest home) were on respite (carer support), one (rest home) resident was on a long-term services – chronic health conditions (LTS-CHC) contract and one resident (rest home) was on a Waikato DHB 'rest and recuperation' contract. All remaining residents were on the age-related residential care contract (ARCC).</p> <p>Kenwyn Rest Home, purchased in 2009, is a family run business. They also own Cardrona Rest Home in Putaruru. An annual business plan has been developed that includes an aim, strategy and measurable goals. Business goals are regularly reviewed with the clinical operations manager, and general manager.</p> <p>The experienced clinical operations manager is a registered nurse (RN) with many years of nursing experience in aged care and has been in a leadership role at this facility for the past eight years. In</p>

		<p>June, she completed a qualification as a registered nurse prescriber. She receives support from a general manager who holds a business background. Together they share one full time position and split their hours between the two aged care facilities owned by the owners. They are supported by a team of care staff that includes six RNs, thirty-four caregivers, one enrolled nurse (EN), and three activities staff.</p> <p>Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities.</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>During the absence of the clinical operations manager/RN, the second in charge (2IC) RN assumes clinical responsibilities. Administrative responsibilities are delegated to the general manager. The clinical operations manager is responsible for administrative responsibilities in the absence of the general manager.</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>A quality and risk management programme is in place. Interviews with the general manager, clinical operations manager/RN, and staff confirmed their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies (sighted).</p> <p>Quality data collected is collated and analysed using the run chart methodology. Quality data is regularly communicated to staff via monthly staff meetings and through the use of graphs that are posted each month in the staff room. The run charts used to display trends (eg, falls) provides staff with meaningful information.</p> <p>An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. A quality improvement register is maintained that keeps a running tally of quality initiatives</p>

		<p>through the use of a quality improvement register (QIR). Examples provided during the audit included the purchase of new pressure mattresses, initiatives to enhance communication with families, and initiatives implemented to reduce staff turnover (link CI 1.2.7.3).</p> <p>Staff are informed of results, evidenced in the monthly staff meeting minutes. Staff sign and read the meeting minutes.</p> <p>A health and safety programme is in place. An interview with the health and safety officer (clinical operations manager) and review of health and safety documentation confirmed that robust health and safety processes are being implemented. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review 7 January 2020). Health and safety checks take place monthly.</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>An accidents and incidents reporting policy is in place. Fifteen accident/incident forms were reviewed (two staff work injuries, eight falls with neurological observations completed for six of the falls (unwitnessed with a possible injury to the head), four skin tears and one pressure injury). There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse.</p> <p>Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.</p> <p>The clinical operations manager is aware of the requirement to notify relevant authorities in relation to essential notifications with examples provided (two stage 3 pressure injuries, assault of a resident).</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>There are human resources management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in eight staff files randomly selected for review (two RNs, six caregivers).</p> <p>Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all eight staff files. Staff have also signed that they have read the staff induction handbook. Staff appraisals are completed annually. Appraisals include input from one (pre-selected) staff member. Staff turnover has reduced significantly following the implementation of several quality initiatives which begins during the applicant's interview and continues</p>

		<p>through their extended period of orientation. This has resulted in a rating of continuous improvement.</p> <p>An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to): nurse specialists, Aged Concern and the Health and Disability Advocacy Service. Three of six RNs have completed interRAI training. There is a minimum of a first aid qualified staff on duty 24 hours a day, seven days a week and while out on outings with residents.</p> <p>Sixteen of nineteen caregivers who work in the dementia unit have completed a New Zealand Qualification Authority (NZQA) approved dementia qualification. The remaining three caregivers have either been employed less than 18 months or have been working in the dementia unit for less than 18 months.</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>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. A clinical operations manager/RN is on-site 3.5 days a week. In addition to her role as a clinical operations manager she also covers as a nurse prescriber approximately four-five hours a week depending on the care needs of the residents. The general manager is on site 1.5 days a week, covering in the absence of the clinical operations manager.</p> <p>The rest home/hospital (25 rest home, 14 hospital residents) is staffed with 1 RN each shift. A second RN is on site eight to sixteen hours a week to complete interRAI assessments. Three long shifts (7-8 hours) and five short shift caregivers cover the AM shift, three long and one short shift caregivers cover the PM shift and two long shift caregivers cover the night shift.</p> <p>The dementia unit (17 residents) is overseen by the RN covering the rest home/hospital. Two long shift and two short shift caregivers cover the AM shift, three long shift caregivers cover the PM shift and one long shift caregiver covers the night shift. An EN covers in place of a caregiver on the AM and PM shifts (part-time).</p> <p>Extra staff can be called on for increased resident requirements. Activities staff are rostered seven days a week in the dementia unit and five days a week in the rest home/hospital. There are separate domestic staff who are responsible for cleaning and laundry services.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.</p> <p>Residents' files demonstrated service integration. Entries are legible, dated, timed and signed by the RN/carer and include their designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry for short-term stays, rest home, and hospital and dementia level of care services. The information pack includes specific information on dementia care and the secure environment. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement.</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>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family occurs.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, enrolled nurses and medication competent caregivers) have been assessed for competency on an annual basis. The RN checks incoming medication blister packs against the electronic medication chart and signs a paper-based verification form and the back of the blister pack when the packs have been checked. Medication is stored safely within the rest home/hospital and dementia units. Expiry dates for 'as required' medications and bulk supply order (for hospital level residents only) are checked regularly by the RN. All medications were within the expiry dates. Eye drops had been dated on opening. Medication fridge temperatures and room temperatures are monitored and recorded daily. There were no residents self-medicating. There are systems in place in the event a resident is self-medicating, including safe storage and self-medication competencies.</p> <p>All 16 medication charts reviewed met legislative prescribing requirements. The NP or GP had reviewed the medication charts three-monthly. All medications had been administered as prescribed.</p>

		There were photographs, and allergy status identified on the medication charts. The effectiveness of 'as required' medication was recorded on the electronic medication chart and in the resident progress notes.
<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>A cook manages and oversees the food service at the facility. The cook is supported by two other cooks and kitchenhands. The food control plan has been verified and expires 6 April 2020. The four-week menu has been reviewed by a dietitian. The main meal is at midday. The cook receives dietary profiles for each resident and is notified of any dietary changes. Dislikes are known, and alternative foods provided. Pureed meals are provided. Nutritional snacks are available 24 hours in the dementia unit and rest home, hospital. The cook serves meals to the rest home and hospital residents from bain maries in the dining room. Meals are delivered to the dementia care unit and to residents' bedrooms as required on trays.</p> <p>A daily checklist is completed, which includes fridges, freezer and chiller temperatures, end-cooked food (at mealtimes), cooling temperatures, chilled/frozen goods on delivery and dishwasher rinse and wash temperatures. All perishable goods were dated, as were the dry goods in the pantry. A cleaning roster is maintained for cooks and kitchenhands. All kitchen staff have completed food safety training.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment on admission including applicable risk assessment tools such as falls, pressure injury, continence, pain, nutritional assessments and behaviour assessments. An interRAI assessment is undertaken within 21 days of admission, six-monthly, or earlier due to significant changes in health for long-term residents. InterRAI assessments have been completed for the resident on the long-term chronic health condition contract.</p>

		Resident needs and supports identified through the assessment process, allied health notes, discharge summaries and information gathered from the resident/relative, form the basis of the initial support plan and long-term care plan. InterRAI assessments, assessment notes and summary were in place for all resident files sampled. Outcomes of behaviour assessments completed for the dementia care residents were reflected in the 24-hour behaviour management plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused and individualised. Support needs for identified risk or changes to care were documented in the care plans for resident care plans reviewed. Short-term care plans had been utilised for short-term needs such as weight monitoring, wounds, pressure injury, and infections. Short-term care plans are reviewed and if an ongoing problem, added to the long-term care plan. Behaviour management (action) plans were in place for the dementia care files reviewed with de-escalation strategies including a 24-hour activity plan that identifies the resident's pattern of behaviour over 24 hours. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were notified of an upcoming multidisciplinary (MDT) review and were involved in the care planning process. Resident files demonstrated service integration. There was evidence of allied health care professionals involved in the care of the resident including the GP, NP, geriatrician, wound nurse specialist and mental health services.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families, and notifications, are documented on the resident family/whānau communication record held in the resident file. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment, evaluations were in place for the 15 residents with wounds across the facility (skin tears, lesions, pressure injuries and chronic wounds). One resident had three wounds. There were four residents with pressure injuries. This included one resident with a grade one pressure injury acquired prior to admission; one resident with a grade one facility acquired pressure injury; one resident with a grade two facility acquired pressure injury; and one resident with a facility acquired grade three pressure injury. An incident form had been completed and a section 31 form had been completed. The clinical operations manager provides expertise in wound management and the service

		<p>accesses the expertise of the NP and wound nurse specialist as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Monitoring occurs for weight, vital signs, pain, repositioning, food and fluid intake, neurological observations, and challenging behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service has a team of activities coordinators who oversee the activity team. Two activities coordinators provide activities in the rest home and hospital service five days a week; and two activities coordinators provide activities seven days a week in the dementia service. There is a van driver who assists with outings.</p> <p>Care staff assist residents to attend activities of their choice within their unit or to a combined activity. Caregivers who work in the dementia unit incorporate activities into their role as observed on the day of audit.</p> <p>The programme is planned to reflect the cognitive and physical abilities of the groups of residents. Activities offered include (but are not limited to): exercises (sit and be fit); newspaper reading; board games; quizzes; bowls; reminiscing; music; hangman and bingo. One-on-one time is spent with residents who are unable to participate or choose not to join in group activities. Other community visitors include church services, entertainers, kindergarten visits and pet therapy. There are outings or scenic drives to places of interest and the countryside. One-on-one time is spent with residents in the hospital, rest home section.</p> <p>Activities in the dementia care unit are flexible and meaningful for the individual resident and include reminiscing, sing-a-longs, walks and domestic activities. The activities coordinator spends one on one time with residents such as reading, chats and walks. Each resident has a 24-hour activity plan that is personalised with the resident's daily activities, potential behaviours and de-escalation strategies including activities. The activities coordinator is involved in the six-monthly evaluation of the 24-hour activity plan, behavioural management plan and care plans with the MDT.</p> <p>A resident profile is completed within three weeks of admission and an activity plan completed on admission, in consultation with the resident/family (as appropriate). Activity plans in all files were evaluated six-monthly.</p> <p>There is an opportunity for residents and families to provide feedback and suggestions for the programme through resident meetings, surveys and one-on-one feedback. Residents and relatives interviewed on the day of audit commented positively on the activity programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed in long-term resident files had been evaluated by the RN within three weeks of admission. There is a three-monthly review of care, this was sighted in resident's files and includes a comprehensive review of cares with family input. Long-term care plans had been evaluated six-monthly against the resident goals, indicating if the goals had been met or unmet. Input in the MDT review meeting includes input from the family/resident (as appropriate), RN, activities coordinator, NP, GP and any allied health professionals involved in the care of the resident. Short-term care plans sighted for short-term problems had been evaluated regularly and included sufficient detail to guide staff in delivery of care. The NP or GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and there were changes made to care plans.</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>	FA	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence that residents had been referred to the physiotherapist, dietitian, and geriatrician, mental health services for older people, urology and palliative care consultant. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. There was evidence of referral to the need's assessment team for re-assessment of level of care from rest home to hospital level of care.</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>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Chemicals are dispensed through a pre-mixing system. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. Staff were observed wearing appropriate personal protective clothing when carrying out their duties. A chemical spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	<p>The building has a current warrant of fitness that expires 11 April 2020. There is a maintenance manager employed 20 hours per week who actions daily requests for maintenance and repairs and completes a maintenance programme as required with pest control and water temperature monitoring is being completed quarterly. There is a maintenance request record kept at the main entrance.</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Repairs are signed off as completed. Essential contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The hoists, scales and clinical equipment is checked/calibrated annually. Hot water temperatures have been monitored monthly and were within the acceptable range.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids or transferring residents to communal areas in hospital lounge chairs. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained with seating and shade available.</p> <p>The dementia unit garden and grounds are safely fenced. There are two doors to the dementia garden area that allow for free access to the garden area with walking pathways, seating and shade. There is safe access to all communal areas in the dementia care unit.</p> <p>Registered nurses interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</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>Resident rooms include rooms with ensuites and rooms where the residents use communal toilets and showers. There are privacy signs on all toilet/bathroom doors. Fixtures, fittings and flooring are appropriate for ease of cleaning. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. Rest home and hospital residents interviewed confirmed staff respected their privacy when carrying out hygiene cares.</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 sufficient space in all residents' rooms to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	<p>FA</p>	<p>The rest home/hospital unit has a large dining room, a large lounge, a library and a central courtyard. The dementia unit has a spacious open plan dining and lounge area, a quiet room and safe access to</p>

<p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>the secure garden and grounds. There is a hairdressing salon for the visiting hairdresser to use.</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>	<p>FA</p>	<p>There are documented systems for monitoring the effectiveness and compliance with the service's policies and procedures. All laundry is done on site in a laundry located in the facility. The laundry operates seven days a week. The laundry workers have completed chemical safety training. There is a defined clean/dirty flow with an entry and exit door. There is a separate drying room and adequate bench space for folding of linen.</p> <p>There are two full-time cleaners on duty Monday to Friday to complete cleaning duties for the facility. There is one cleaner on duty on Saturdays to complete a basic clean for the facility. Cleaning staff have completed chemical safety training. Cleaning trolleys sighted were well equipped and all chemicals labelled correctly. Personal protective equipment is available. The cleaners' trolleys when not in use, were stored in locked areas at each end of the facility.</p> <p>The chemical provider monitors the cleaning and laundry service and chemical use and effectiveness.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available. Civil defence, first aid and pandemic supplies are checked monthly</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. The double room has a call bell accessible for each resident.</p> <p>There is a minimum of one staff available 24 hours a day, 7 days a week with a current first aid/CPR certificate. Activities staff who accompany residents on outings also hold a current first aid/CPR certificate.</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>	FA	<p>All resident bedrooms have external windows with plenty of natural sunlight. The facility has air-conditioning and electrical heating in place. There are windows and doors that open for ventilation. The facility was maintained at a comfortable temperature on the days of the audit.</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 Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme was last reviewed in January 2020.</p> <p>The IC policy and procedures are available. There is a job description for the IC coordinator (clinical operations manager) which includes clearly defined guidelines and responsibilities. The IC issues and surveillance data are used in the quality improvement management meetings. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. Residents and staff are offered the influenza vaccine. A pandemic plan is in place and PPE was available that was set aside for use in a pandemic.</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>There is a designated IC coordinator who has completed external IC training. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator has good external support from the public health authorities and the local DHB. The IC team includes all staff and is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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</p>	FA	<p>The IC policies and procedures defines roles, responsibilities, oversight, the IC team, training and education of staff. IC policies are supported by the clinical operations manager and the service maintains the most up to date documents.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Kenwyn Rest Home is committed to the ongoing IC education for staff and residents. Formal IC education for staff has occurred and is part of the annual education programme. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. IC education is provided by the IC coordinator who maintains the most up to date knowledge.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The IC surveillance programme is implemented. The programme is appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Individual resident infection forms are completed, and short-term care plans are used. Outcomes and actions of IC episodes are discussed during the quality improvement component of the staff meeting. If there is an emergent issue, it is acted upon in a timely manner. The NP interview confirmed prompt notification of individual infections cases. The short-term care plan is also used in monitoring and review of IC data. There has been no outbreak since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. Four hospital level residents were using restraints (four bedrails, one lap belt) with one resident using two restraints and one hospital level resident was using a bedrail as an enabler. An enabler assessment was completed and written consent was provided by the resident for the use of this enabler. Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year.
Standard 2.2.1: Restraint approval and processes Services maintain a process for	FA	The restraint coordinator is an RN (2IC). Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed in the monthly staff meetings.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. Two residents' files where restraint was being used were selected for review. Each resident using restraint had a restraint assessment completed. Family had signed informed consent for restraint use. The restraint assessment and residents' care plans addressed the risks associated with restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is being implemented. The register identifies the residents that are using a restraint or an enabler. Four hospital level residents were listed on the restraint register as using a restraint. The two restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint policy indicates that all residents are monitored two-hourly at a minimum. Restraint use is linked to the residents' care plans and includes the potential risks associated with the restraint. Monitoring forms for the two residents' files reviewed were completed two hourly and included when the restraint was put on and when it was taken off. There have been no incidents reported around the use of restraints.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint evaluations take place six-monthly in conjunction with the care plan reviews. Restraint use is also discussed in the monthly staff meetings. This was confirmed in the staff meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of	FA	The restraint minimisation programme is discussed and regularly reviewed by the clinical operations manager and restraint coordinator. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and competency assessments.

their use of restraint.		
-------------------------	--	--

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.

No data to display

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 clinical operations manager was approved to prescribe in primary health and specialty teams in July 2019, which has improved on the overall timeliness and efficiency when dealing with unwell residents. To meet the legal and supervision requirements of the position, communication channels were developed with the local GP practice. This included access to their patient management</p>	<p>A registered nurse prescribing policy and associated guidelines have been developed and implemented. To meet legal and supervision requirements for this new role, communication channels were developed including triage arrangements. Since this time, the clinical operations manager has provided assessment and prescribing for palliative residents as well as managing residents with diabetes, chronic obstructive pulmonary disease (COPD), pneumonia and other common infections. GP consultations have reduced from 146 (January 2019 – July 2019) to 63 (August 2019 – February 2020). Hospital admissions from infections have also reduced with two admissions from pneumonia February – June 2019 and no hospital admissions for infections since June 2019. This is believed to be the direct result of closer monitoring and management. One letter reviewed from a GP at Health Te Aroha who visits residents at Kenwyn Rest Home stated, ‘Having a prescriber on site leads to quicker assessment and treatment of patients, and therefore better outcomes for patients’ and went on to commend the clinical operations manager for her teamwork and increased skills. The nurse practitioner from the GP practice who visits residents three monthly stated that the level of nursing provided by having a nurse prescriber at Kenwyn ‘ensures that the older people of</p>

		system and the development of triage arrangements.	Kenwyn get preferential and superior care due to the immediacy of her care and input.'
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	CI	<p>The staff turnover rate has reduced substantially over the past three years due to quality initiatives that have been implemented beginning when an applicant is interviewed for a position.</p>	<p>Staff turnover is a key performance indicator that is reviewed annually. It is felt that staff that are happy and satisfied in their work do a better job; and a stable team provides better continuity of care for residents. Staff turnover in 2016 was 28%, 30% in 2017, 33% in 2018 and 13% in 2019. Quality initiatives implemented have included; 1) Taking additional time to conduct more robust interviews to look for applicants with the best fit; 2) Altering the caregiver staff orientation process whereby instead of buddying new staff with a more experienced caregiver for two days, caregiver staff are buddied with a caregiver who has a level four Careerforce qualification who buddies with the new caregiver over a longer period, regularly checking in with the new staff to see how they are progressing; 3) Appraisals are competency based and include a team worker peer review; and 4) Care staff have been issued with smarter, more professional looking uniforms. Interviews with staff reflected an atmosphere of pride and teamwork. Resident satisfaction survey results (January 2020) have improved with all 16 (100%) of respondents reporting that they are either satisfied or very satisfied with the services provided compared to an 83.2% satisfaction rating at the last survey.</p>

End of the report.