

Akaroa Health Limited - Akaroa Residential Care Centre

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:	Akaroa Health Limited
Premises audited:	Akaroa Residential Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 November 2020 End date: 18 November 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:	9

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

The Akaroa Residential Care Centre is located on the site of the old hospital in Akaroa and has now been operating for approximately eighteen months as part of an integrated family health care centre. This first full certification audit has been delayed due to the impact of Covid-19 with the certificate extended for up to twelve months from the original September 2020 due date. In 2019, HealthCert approved that the two medical beds become four medical beds, and the eight rest home beds become dual hospital medical and or geriatric/rest home beds. The total number of beds increased from 10 to 12 at that time. The purpose-built facility provides rest home and hospital level care and is co-located with a general practice. The building is owned by Canterbury District Health Board and leased to the Akaroa Community Health Trust operating as Akaroa Health Limited (AHL).

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 files, observations and interviews with management, staff, and board members. Residents and family members interviewed were full of praise for the service and staff and appreciated the purpose built but homely environment.

The audit has resulted in two areas requiring improvement relating to medication competencies for registered nurses and cleaning practices.

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.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

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

There is a Māori health plan available for residents who identify as Māori to have their needs met in a manner that respects their cultural values and beliefs. 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.

A complaints register is maintained with complaints resolved promptly and effectively. The facility manager is responsible for the management of complaints. Complaints were managed in accordance with the requirements of the Code.

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.
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Akaroa Community Health Trust is the governing body, with Akaroa Health Limited responsible for the service provided at this facility. A business plan and quality and risk management plan are documented and included the scope, direction, goals, values, and a mission statement. Systems are in place for monitoring the service provided, including regular reporting to the governing body by the general manager.

The facility is managed by an experienced and suitably qualified general manager who is a registered nurse. She is supported by a clinical nurse leader responsible for oversight of the clinical services.

There was evidence that quality improvement data is collected and collated. Data is being reviewed, analysed, and compared with previous results. Relevant clinical data details are reported to the quality meetings. There was a comprehensive internal audit programme in place and internal audits have been completed on schedule. Corrective action plans have been developed to address areas identified as requiring improvement. Risks are identified, with higher risks reviewed regularly by the Board. The hazard register was up to date. Adverse events were documented on hard copy accident/incident forms.

There are policies and procedures on human resources management. Practising certificates were current for health professionals who required them. Best practice human resources processes are followed including reference checks and police vetting completion for all potential employees.

Training records indicated orientation completion for new staff. An in-service education programme was provided for staff, an annual staff study day is held, and other opportunistic training is provided as part of the staff meetings as well as access to online learning. Staff are also required to complete the New Zealand Qualifications Authority Unit Standards, although most care staff hold a level three or level four qualification. The nature of the community requires staff to have additional competencies relevant to medical emergencies. This includes some staff holding PRIME qualifications or who are St Johns First Responders. Review of staff records evidenced individual education records were maintained.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The general manager and the clinical nurse lead are available by phone and registered nurses cover the service twenty-four hours per day, seven days per week. Care staff reported that adequate staff are available and that everyone works together as a team to enable them to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

The privacy of residents' information was maintained in a secure manner and other service information is secured, archived and retrievable when required.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans were individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents were referred or transferred to other health services as required.

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

Medicines were safely managed and administered by staff who were competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food was safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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All building and plant complied with legislation, and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme included equipment and electrical checks. The environment is appropriate to the needs of the residents with bedrooms being approved as dual-purpose rooms for use by residents who require either rest home, hospital level care or respite care.

Residents' rooms are spacious to allow for ease of care provision and for the safe use and manoeuvring of mobility aids. Equipment such as hoists suited to the needs of residents, is available.

Waste management, cleaning and laundry services are implemented in accordance with relevant policies and procedures.

Essential emergency and security systems were in place with regular fire drills completed. A backup generator is about to be installed and there are adequate amounts of potable water available in an emergency. A call bell system allows residents to access help when needed and residents reported that these are answered in a timely manner.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has documented policies and procedures for restraint minimisation and safe practice with a focus on the least restrictive option. Systems were in place that ensured assessment of residents is undertaken prior to restraint or enabler use. Enabler use is voluntary.

There were no residents using restraint. There was one resident using an enabler of their choice. There was an example of alternatives to the use of restraint documented for one resident. Staff education includes all required aspects of restraint and enabler use along with alternatives to restraint and behavioural management. Staff described the difference between a restraint and 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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent, and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action was taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	91	0	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Akaroa Residential Care Centre has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, last provided at a study day in July 2020.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's admission agreement. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

<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>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this, and their right to have support persons. The CNL provided an example of the ongoing involvement of Advocacy Services in relation to loss of a residents' property during the move to the new facility.</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>	<p>FA</p>	<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 diversional therapist confirmed that community involvement is particularly important to the activities programme.</p> <p>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 dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The general manager is responsible for complaints and there are systems in place to manage the complaints processes. A complaints register is maintained that included one complaint in the past year. This was managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents spoken to understood these processes. Information about the complaints process was readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting back of complaints and concerns to staff.</p> <p>One resident's complaint has been investigated by the Health and Disability Commissioner (HDC) via the Advocacy Service. This has been satisfactorily resolved. Documentation reviewed indicated this investigation was now closed, with all actions and responses in accordance with the timeframes outlined in the Code. There have been no investigations by the Ministry of Health, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through information provided on admission and discussion with staff. The Code is displayed at the reception of the medical practice and on notice boards in each wing of the</p>

<p>Consumers are informed of their rights.</p>		<p>facility together with information on advocacy services, how to make a complaint and feedback forms. If residents make a complaint, they are reminded of their right to have an advocate present at any discussions.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff were observed to maintain privacy throughout the audit by knocking on doors and taking residents to their rooms for private conversations. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence through involvement in community activities, both individually and in groups. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Five residents' records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and at a study day in July 2020. Residents and family members interviewed reported that they had never seen or experienced any signs of abuse, neglect, or discrimination.</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>On the day of audit there were no residents who identified as Māori but there is a current Māori health plan available with input from advisors from Ōnuku Runanga marae. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. Guidance on tikanga best practice is available.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed for those that wished to attend church services or have visits from the priest. The residents interviewed confirmed that individual needs are being met.</p>

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation programme for staff includes education on professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention from GPs or one of three 'prime response in medical emergencies' (PRIME) staff from the medical practice when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as HealthLearn, Goodfellow unit, mobile health webinars, and attend study days by New Zealand Aged Care Association.</p> <p>Other examples of good practice observed during the audit included a recent review of the medication management system to clarify prescribing, delivery and administration of medications which has resulted in a decrease in medication errors.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in the five residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The clinical nurse lead (CNL) gave an example of ongoing communication in relation to a resident's special needs.</p> <p>Staff know how to access interpreter services, although reported this has not been required due to all</p>

		residents being able to speak English.
<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>Subsequent to the 2010 and 2011 earthquakes, it became necessary to replace several key services housed in earthquake damaged buildings for the people of Banks Peninsula. In 2017 the Akaroa Structure Group established Akaroa Community Health Trust (AHT). The Akaroa community recruited Trustees plus representation from Ōnuku Marae and Christchurch City Council's Community Board to govern AHT. AHT recruited Directors to govern Akaroa Health Ltd (AHL), a charitable company, to operate and manage the new health facility and take the lead in integrating service delivery across the providers within the Akaroa community.</p> <p>A new model of care was released to the community in early 2018 and continues to evolve as new health needs are identified and different ways of delivering services are developed and implemented in the community. The first full review is now underway. AHL purchased the GP Practice with effect from 1 April 2018. The aged residential service contract was transferred to AHL (eight beds) and a health services contract to provide and bulk fund four flexi beds was agreed to by CDHB and AHL in May 2019. By August 2019, all services were shifted into the new Health Centre, all under AHL management.</p> <p>In July 2020, AHL Board and the General Manager undertook a strategic planning workshop. The AHL strategic action plan for 2020 was developed with five key themes for action. Theme three is a review of the Model of Care and the development of patient outcome metrics. These metrics contribute to an AHL balanced score card, including objectives from other documents such as the AHL Maori Health Approach. The balanced score card framework being developed will replicate the strategic goals (i.e. patient and community, organisation systems, staff, and finances). This was being refined at the time of audit to provide reporting to the Board, the Trust, and the community on the service's performance. The AHL board has a range of skills to call upon. Some of the six trustees have a health background, but there is also financial and legal representation. Care has been taken to separate governance and operations – the chair of AHL sits on the AHT board and vice versa. A Code of Governance guides relationships and behaviours. Two Board members interviewed confirmed the processes, including regular monthly meetings. Minutes were sighted.</p> <p>Documents outlining the AHL Strategic Approach 2018 – 20 were reviewed. This defines the scope, direction, and goals of the organisation, as well as the monitoring and reporting processes against these systems. An organisational chart outlines reporting lines. The general manager provides comprehensive reports to the governing body and speaks to the reports at Board meetings. Interviews with residents and families indicate that the service is highly valued by the local community, with a real sense of ownership and support evident.</p> <p>The facility is managed by an experienced general manager (GM) who is a registered nurse and has been in this position since 2018 to facilitate the change process and development of the new structure and</p>

		<p>service. She has held a number of senior management positions in a range of settings including Capital and Coast DHB. The facility manager is supported by a clinical nurse lead who is a registered nurse. She works three days per week and has oversight of clinical care. Both hold a current Annual Practising Certificate (APC).</p> <p>On the first day of this audit there was one hospital level care resident, seven rest home level care residents and one person receiving short term respite care – a total of nine occupied beds.</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>In the absence of the general manager, the clinical nurse lead deputises. Additional clinical support is provided by the practice manager of the co-located GP practice. Call arrangements are in place. Both the GM and the clinical nurse lead understood their responsibility and authority for their roles. Delegation documents guide actions for the positions.</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 plan has been established to guide the quality programme, which is seen as a driver to providing high quality and safe services for the community. The approach aligns with Health Quality and Safety Commission’s “triple aim”, particularly, improved quality, safety, and experience of care. AHL has added a further aim – a thriving organisation. Purpose, goals/objectives, and scope are included in the plan, which is reviewed annually by the Risk Audit Compliance management group (RAC). The review summarises the organisation’s performance against targets and makes recommendations. The report is tabled at the Clinical Governance Group (CGG) and signed off by the board.</p> <p>A comprehensive risk register has been developed and is regularly reviewed by the Board. Risks are identified and mitigated, with increased monitoring as/if risks change. Examples reviewed indicated that this is an active and well understood and implemented process.</p> <p>Two resident and relative satisfaction surveys have been completed since the facility opened, with questions in relation to food and care. Results indicated a high level of satisfaction with no corrective actions required.</p> <p>Completed audits for 2020 are in accordance with the audit schedule. Where necessary, shortcomings have been followed up with a corrective action or training focus. Review of the quality improvement data provided evidence that data is being collected and collated to identify any trends. When necessary, corrective actions are developed, implemented, and evaluated.</p>

		<p>Quality related meetings included RAC, clinical governance and staff meetings. Infection control, health and safety and restraint, reviewed policy or procedures, and quality audit results are discussed as evidenced in meeting minutes reviewed. Information and minutes are made available to staff and they reported feeling well informed about all aspects of the operation. Consideration is being given to reducing the frequency of the clinical governance meetings to 6 – 8 weekly (This is a whole of service meeting including the GP practice), while retaining RAC at a monthly frequency to better reflect the needs and key indicators relevant to the aged care facility.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted practice, and referenced relevant legislative requirements. The policy covers uncontrolled documents, changes, removal of obsolete documents and storage. Documents are being moved towards being fully electronic, with hard copies about to be phased out. Guidance on how to access these is readily available with screenshots guidance provided. The policies / procedures reviewed were current. Staff confirmed during interview that they are advised of updated policies and they confirmed the policies and procedures provided appropriate guidance for service delivery.</p> <p>A health and safety manual plan 2020 – 21 has been developed, with focus areas defined. These are employer commitment, planning, hazard identification and management, training, incident and accident reporting, employee participation and emergency planning. Health and safety is an agenda item at all meetings, including the board. There is a hazard reporting system and a hazard register that identified health and safety risks. It is maintained separately from the risk register.</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>	<p>FA</p>	<p>Registered nurses and health care assistants document adverse events on an accident/incident form. Samples reviewed are consistently completed. Documentation and interview with the general manager evidenced corrective action has been developed and implemented for a range of events, internal audits or near misses. An improvement register captures some of the corrective action planning undertaken, but it would be beneficial to ensure that all improvement opportunities are systematically captured wherever they are identified. Adverse events are collated and held in hard copy. Analysis and trends are reported electronically and reported in meeting minutes.</p> <p>There is an open disclosure policy. Residents' documentation reviewed provided evidence of communication with families/next-of-kin/enduring power of attorney (EPOA) following adverse events involving the resident, or any change in the resident's condition. This is also confirmed at interview with family members.</p> <p>Policy and procedures have recently been updated to reflect essential notification reporting requirements (e.g., health and safety, human resources, infection control, section 31). Senior staff confirmed they are aware of their notification responsibilities through job descriptions and policies and procedures, as confirmed through review of relevant documentation. There have been no notifications of any significant</p>

		events made to the Ministry of Health since the previous audit.
<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>Current policies and procedures guide human resources management. Recruitment processes are defined but the added advantage of local knowledge is reported by the GM. Some staff have been employed after making their interest and availability known to the service and it is seldom necessary to advertise vacancies. Annual practising certificates for all health professionals who require them were current, including for a recently employed enrolled nurse. The skills and knowledge required for each position within the service is documented in job descriptions which outlined accountability, responsibilities, and authority. These were reviewed along with employment agreements, confidentiality statements, referee checks and police vetting results for seven staff, including most recently employed staff. Staff sign a comprehensive code of conduct at the time of commencing employment.</p> <p>An orientation/induction programme is in place. New staff files reviewed evidenced an orientation had been completed. Orientation for staff covers the essential components of the service provided. Staff who were redeployed from the previous facility were also given opportunities to familiarise themselves with the new environment when the facility opened. Staff performance is reviewed at the end of the orientation period. Performance appraisals are completed annually and were up to date or scheduled for staff requiring them. Care staff also confirmed their attendance at on-going in-service education and that their performance appraisals were current.</p> <p>The clinical nurse lead is responsible for oversight of the in-service education programme. Individual records of education are maintained for each staff member and were reviewed at audit. Review of the education programmes for 2020 evidenced education is provided in various ways (e.g., via study days, online training, at staff meetings and opportunistic external education by visiting specialist medical, nursing, and allied health staff such as from the palliative care team and wound care nurses). Seven of nine registered nurses responsible for medication management have undertaken additional training; however, the organisation has not defined the competency requirements for these staff (see CAR 1.3.12.3). Health care assistants all have records of current medication competencies. There are records of completion of mandatory training requirements including the required HealthLearn modules. Records were maintained in a spreadsheet.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme – most have completed this to at least level three standards. A new staff member has recently commenced level two. A registered nurse is the internal assessor for the programme. Several staff also have other facility or community roles such as St Johns first responders or are PRIME nurses. Registered nurses who cover all three shifts hold current NZ Resuscitation Council certification, with health care assistants completing a First Aid course through St Johns.</p> <p>A qualified diversional therapist works twenty-one hours per fortnight and maintains networks in the sector.</p>

		She also fills HCA shifts. Three staff cover cooking roles over the seven-day period, and all hold a food safety qualification. Health care assistants (HCAs) have also received food handling training suited to their need to reheat food for the evening meal. There is one trained InterRAI assessor with current competency.
<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 that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and one health care assistant. The general manager or the clinical nurse lead share on call after hours. Registered nurses cover all shifts on a rotational roster. During the weekend and afterhours either a senior registered nurse or GP are rostered for PRIME on call. Health Care Assistants interviewed reported there were adequate staff available and that they were able to complete the work allocated to them. They commented that they work as a team, with both the clinical nurse lead and general manager helping out if required. Residents and family interviewed reported there was enough staff on duty that provided their relative with adequate care. Observations during this audit confirmed adequate staff cover was being provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP/PRIME and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. There was one resident receiving respite care on the day of audit who expressed satisfaction with the service.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. The CNL confirmed that many of their long-term residents</p>

		were familiar with the service having been respite residents prior to becoming permanent residents. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses an electronic system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. If the resident is being transferred to another facility a verbal handover is given via telephone. All referrals are documented in the progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a paper-based system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. HCA staff who administer medicines are competent to perform the function they manage. The registered nurses while having training in medication management do not have a process where they are signed off as being competent, resulting in a corrective action required.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely, in a safe in the medical practice, in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review were consistently recorded on the medicine chart. The residential aged care service does not use standing orders.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if it should be required.</p>

		There is an implemented process for comprehensive analysis of any medication errors.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by three cooks and a kitchen hand and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (July 2019). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry for Primary Industries current until 22 January 2021. Food temperatures, including for high risk items, are monitored appropriately, and recorded as part of the plan. The cooks have completed a certificate in catering, level three.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents verified that they have input into the meals by a monthly event, 'Monday menu' where they are able to choose what they would like to have on the menu. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family. The CNL gave an example of a respite resident no longer able to be safely managed which enabled the family to request reassessment and appropriate level of care sought. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the one interRAI trained assessor on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were highlighted and reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified the care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders were followed, and care was of a high standard. Care staff confirmed that care was provided as outlined in the documentation and that they had input into the care planning. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist (DT) holding the National Certificate in Diversional Therapy who has been working at the facility three days a week for seven years. HCAs will implement pre-set activities when the DT is away.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on a daily basis by noting engagement and as part of the three-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities, such as attending school productions and local events. Individual, group activities and regular events are offered including quizzes and entertainers. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme engaging.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for wound care and skin conditions. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. All residents are seen by medical staff from the onsite medical practice. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the nephrology department and a skin specialist. Physiotherapist referrals are of a verbal nature with the physiotherapist in the medical practice. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately by either a GP or PRIME staff member, who assess the situation and take appropriate interventions, such as sending the resident to accident and emergency in an ambulance or helicopter if the circumstances dictate.</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>Documented processes for the management of waste and hazardous substances are in place, including the need to report any incidents in a timely manner. Chemicals are stored safely in locked cupboards or the cleaning cupboard. Material safety data sheets are available for all products sampled and are available for staff use. Bulk supplies are decanted into labelled bottles for use in the various service areas. The hazard register is current. Staff received training and education to ensure safe and appropriate handling of hazardous substances.</p> <p>A contracted provider collects infectious and medical waste which is stored in a locked outdoor cage to prevent unauthorised access. Council waste bins are available for general rubbish.</p> <p>There is an adequate supply of personal protective clothing and equipment that is appropriate to the recognised risks and which is made available to staff. Protective clothing and equipment is readily available for residents in isolation and in the laundry and sluice rooms. Staff were observed using the</p>

		protective clothing provided and have been trained in the use of PPE and in correct donning and doffing.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed in the entry, expiring 1 August 2021. Records of regular monthly building inspections for compliance are maintained.</p> <p>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 proactive and reactive maintenance programme in place and buildings, plant and equipment are maintained to an adequate standard following the initial 12-month builders warranty period. Some building responsibilities remain with the landlord (CDHB). A maintenance person is available to undertake minor repairs and maintenance on a voluntary basis. The testing and tagging of equipment and calibration of bio medical equipment was current, with all equipment to be included in a retest booked for 8 December 2020. Water temperatures are monitored manually at the tap and recorded weekly, however there is also a sophisticated monitoring system for the facility linked to the CDHB electronic facility management system. Monitoring of ambient and underfloor room heating and water temperatures produced through an instant hot water system occurs on an ongoing basis. There is some ability to reset temperatures within the building using the electronic building dashboard. A trade waste certificate is dated 5 November 2019.</p> <p>There are external areas available for residents. A courtyard is about to have additional shade added in the form of a pergola, as well as some beautification with plantings. Residents have access to external areas and were seen to access a safe walking pathway on several occasions during the audit. A community group provides gardening services on a rostered basis. The environment is conducive to the age and mobility needs of the residents. There is an easily accessible covered shed with power for the charging of several electric scooters adjacent to a side exit.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they have received any necessary training in its use. The community and other groups have generously supported the equipment needs of the facility, with most items being newly purchased (e.g., electric beds, a fold out bed for the palliative care room and clinical observation equipment).</p> <p>Residents interviewed confirmed they know the processes they should follow if any repairs/maintenance are required and also that staff are proactive in ensuring items are safe to use or repaired in a timely manner.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	FA	<p>All twelve bedrooms have a separate ensuite bathroom, with raised toilet seats, flat entry showers and appropriately located handrails. There are adequate numbers of communal bathrooms and toilets throughout the facility, such as adjacent to the lounge for resident ease of access. Residents interviewed</p>

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		find proximity of bathrooms to be useful, whether in public or private spaces. Other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided to allow residents and staff to move safely within the bedroom areas. All bedrooms provide single accommodation. Residents spoke positively about their rooms which are personalised with furnishings, photos, and other personal items. There is room to store mobility aids such as wheelchairs and hoists in storage areas or specifically designed spaces that do not create a mobility hazard.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are a number of areas for residents to spend time socialising, relaxing or participating in activities. While the spaces are not large, they are comfortable and uncluttered, with suitable furniture and furnishings. A small tea making area is available for residents or family/whānau use. There is a separate dining room, with access to filtered water at any time. Residents were noted to spend unhurried time to finish their meals and to socialise. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely and be able to watch television, play cards or participate in activities. Residents reported they are enjoying the fresh new environment which is comfortable and warm.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low	All personal laundry and towels are washed on site in a dedicated laundry. Larger items such as sheets and bedcovers are sent to a contracted laundry in Christchurch each week. Residents reported the laundry is managed well and their clothes are returned in a timely manner. Staff are reported to take pride in keeping resident clothing in a clean and well-kept state. Care staff responsible demonstrated a sound knowledge of the laundry processes. There is a dedicated cleaner employed for the general practice who also undertakes some cleaning in the public areas of the residential facility. However, most cleaning is undertaken by care staff as part of their daily duties. Two staff described the processes, use of chemicals and the cleaning activity itself. Staff have received appropriate training, including in chemical use. The cleaning cupboard is kept locked. It includes for items stored in the laundry. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. Improvement is needed in relation

		to use of mops.
<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>The evacuation plan was approved by the New Zealand Fire Service on 9/8/19. An evacuation policy on emergency and security situations was in place. A trial fire evacuation was undertaken in October 2020 with a copy of the six-monthly practice sent to the New Zealand Fire Service. The GM reported that the next trial evacuation may be scheduled when there are lower staffing levels. The orientation programme includes fire and security training.</p> <p>The building is locked down each night as part of a security check and there is a well-lit car park adjacent to the building. Entry to the building is gained when staff open the doors out of hours. They are able to visualise any visitors before providing entry. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member on duty with a current first aid certificate or advanced life support certificate.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and torches. Checks are conducted monthly on the content and functioning of items in the civil defence boxes.</p> <p>There are call bells to alert staff, with location boards situated in the corridors. An audible sounder has been added for the dining room, as staff are unable to hear the call bells from the two wings when working in this area. This is proving to be an effective system. Residents and families reported staff respond promptly to call bells and this was observed to occur during the audit.</p> <p>A generator has recently been purchased and is enroute from overseas. It will be commissioned on arrival and is able to meet the ongoing power needs of the site including power, lighting, and heating. Solar panels are providing an additional power boost and any surplus is fed back into the grid.</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</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with safe ventilation with partial opening windows, and an environment that is maintained at a safe and comfortable temperature. Initial issues were encountered with maintaining consistent temperatures in the building, but these are now resolved. Heating is provided by underfloor heating and an HVAC system. The building is smoke free. All resident areas are provided with natural light.</p>

temperature.		
<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 (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually and signed off by the chair of the board (14 February 2020).</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager, and tabled at the quality meeting.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. There is a QR code to track and trace for Covid-19. Families interviewed said they were well informed of processes during each different level of Covid-19 restrictions.</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 IPC coordinator has appropriate skills, knowledge, and qualifications for the role, and has been in the role for ten years. She has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the GP, and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any 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</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2020 and included appropriate referencing.</p> <p>All staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation, and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions with extra sessions being held during Covid-19 lockdown. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included advice about remaining in their room if they are unwell and hand sanitizing before meals.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, wound, eyes, nose, ears, mouth, and the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Results for the current year, and comparisons against previous years are made and this is reported to the general manager and the board.</p> <p>There have been no reports of any outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has implemented policy and procedures to guide staff in the safe use of restraint or enablers. No restraint has been implemented; however, one enabler was in use at the request of the resident to promote independence and safety. Documentation confirmed this was the resident's preferred enabler and had been provided at their request. There was one example in which restraint use had been actively minimised through interventions such as one on one staff support during a period of restlessness. Consequently, restraint had not been required.</p> <p>Health care assistants have received training in the use of restraints and enablers through a HealthLearn module. They demonstrated good knowledge on their use and strategies for avoiding the use of restraints.</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)
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	The hospital care assistants have a programme in place for gaining medication competency but there is no defined plan in place for the registered nurses to gain medication competency.	While seven of nine registered nurses have undertaken training on HealthLearn in relation to medication management, competency requirements have not been defined.	A programme is defined and put in place to ensure registered nurses are trained and signed off as medication competent on an annual basis. 90 days
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and	PA Low	Cleaning is largely undertaken by care staff and practice is guided by policy. Various types of mop heads are used including “squeegee” and string types according to the area being cleaned. There are different ways in which they are being cleaned and laundered,	There is a lack of clarity about the cleaning process for different types of mops and the expected cleaning processes, including in	Clarify the process for cleaning/laundrying of various types of mops and the expected process in

laundry processes are monitored for effectiveness.		with some variability in staff understanding of the correct process for the “squeegee” type. There is also a lack of clarity in the policy in relation to mop use in isolation rooms. On the day of audit, there was one patient in isolation.	isolation rooms.	isolation rooms. 180 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.