

Cambridge Resthaven Trust Board Incorporated - Resthaven-on-Burns Street

Introduction

This report records the results of a Partial Provisional Audit; 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:	Cambridge Resthaven Trust Board Incorporated
Premises audited:	Resthaven-on-Burns street
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: 10 February 2021 End date: 11 February 2021
Proposed changes to current services (if any):	Reduce the number of rest home designated beds from 18 to twelve and increase dual-service beds from 4 to 10

Total beds occupied across all premises included in the audit on the first day of the audit: 37

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

Resthaven-on-Burns Street provides rest home, dementia and hospital level care for up to a maximum of 54 residents. The facility, which is located in Leamington, Cambridge is owned and operated by the Cambridge Resthaven Trust Board Incorporated, who took over the service on 23 April 2020. The trust have been involved in the aged care sector for many years through community ownership and operation of Cambridge Resthaven another large aged care facility and retirement village.

The service is operated by a long time serving chief executive officer (CEO) and a general manager (GM) and Nursing Director (ND) who oversee both sites. A clinical nurse leader (CNL) works on site at Resthaven on Burns.

This certification and partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and two general practitioners.

Significant changes since takeover include building and external environment improvements, increased staffing levels and a proposed reconfiguration of beds. The service provider's proposal to reconfigure nine rest home beds to 'dual purpose' was amended during this audit. The proposal is now to reconfigure six beds subsequent to building works being completed, procurement of additional equipment and confirmation of staffing levels which reflect the care needs of residents.

Residents and families spoke positively about the care provided.

This audit has resulted in three ratings of continuous improvement in restraint minimisation and safe practice, quality systems and cleaning. There were two areas related to the reconfiguration of beds (staffing and bathrooms) which could not be demonstrated as fully attained on the days of audit.

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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The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents and their family/whānau when admitted to Resthaven-on-Burns Street. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be provided. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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

Organisational management

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

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Resthaven-on-Burns Street work closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is efficiently managed. When a vacancy occurs, sufficient information is provided to the potential resident/family/whānau to facilitate the admission.

Residents' needs are assessed on admission by the multidisciplinary team and within the required timeframes. Shift handovers and an electronically generated communication sheet guides continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents, their families/whānau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is provided by a recreation co-ordinator and provides residents with a variety of individual and group activities and maintains their links with the community. The programme is overseen by a diversional therapist from the associated facility nearby. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed as competent to do so.

The food service is managed by an external provider and meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified a high level of satisfaction with the meals 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.

Some standards applicable to this service partially attained and of low risk.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry is undertaken offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

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

The organisation has implemented policies and procedures that support the minimisation of restraint. One person was using an enabler and one restraint was in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme at the Cambridge Resthaven Trust Board Incorporated sites, that includes Resthaven-on-Burns Street, is led by an experienced and appropriately trained infection control co-ordinator. The programme aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from two external advisory companies and the Waikato District Health Board. The programme is reviewed annually.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	46	0	2	0	0	0
Criteria	3	96	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Cambridge Resthaven Trust Board Incorporated - Resthaven-on-Burns Street (Resthaven) has procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed of residents in the secure unit,</p>

		<p>contained an EPOA and an activation of that EPOA following a mental capacity assessment.</p> <p>Staff were observed to gain consent for day-to-day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>Except for times when Covid-19 places restrictions on visiting, the facility has unrestricted visiting hours and encourages visits from residents' families/whānau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they understood the process and would not hesitate to raise concerns if they had any. Residents are encouraged and supported to raise issues and concerns at their monthly meetings.</p> <p>The complaints register reviewed showed that 38 complaints and 12 compliments have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The general manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family members of residents/whānau when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas around the facility. Information on advocacy services, how to make a complaint and feedback forms was available in the entry foyer.</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 their family members/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Family members/whānau made mention of feeling welcome when they are present and made to feel at home with staff willing to assist when needed.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussions with families and the general practitioners (GPs). Interview with a resident disclosed the door handle on the door of the resident's room was loose and the door kept blowing open, potentially compromising the resident's privacy. This was reported during audit and the door handle was replaced. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and</p>	<p>FA</p>	<p>There were three residents in Resthaven at the time of audit who identify as Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed for these residents.</p>

cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>A resident satisfaction questionnaire was not available to determine feedback on how well residents' cultural needs are met. Residents and family members/whānau 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 all care plans reviewed, for example, food likes and dislikes and attention to preferences around cultural needs and activities of daily living.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members/whānau of residents interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Two GPs also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care nurse specialist, physiotherapist, wound care specialist, community, and the Waikato District Health Board (WDHB) link nurse, aged concern, services for older people, and mental health services for older persons, and education of staff. The GPs confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Nursing practice at Resthaven is overseen by the WDHB link nurse, who is also employed by Resthaven. RN training and competencies are overseen and assessed by the link nurse. RNs at Resthaven are trained in phlebotomy, as Resthaven was having difficulties accessing on site phlebotomists from the local service provider. Additional training and competency assessments occur as the need is identified. All RNs have access to Ko-Awatea, the DHB learning hub, and in addition they are supported to attend conferences relevant to aged care nursing.</p> <p>Through the work of the Community Trust and Care Aotearoa group (CTCA), of which Resthaven</p>

		<p>is a member, RNs at Resthaven have access to a clinical workstation site. This site enables members to have direct access to WDHB reports and results.</p> <p>An in-house nurse educator provides ongoing monthly training sessions for all staff and assists health care assistants with gaining qualifications on the National Qualification framework. Staff were complimentary of the support provided by the organisation in enabling them to do their work well and to a high standard.</p> <p>The general manager (GM), Nursing Director (ND) and clinical nurse leader (CNL) have an open-door policy and are always available to staff/whānau. They acknowledged the work is stressful at times, they are available for support, and discourage staff working long hours. Anyone suffering from stress at work or outside of work has access to assistance from an employee support assistance scheme if they see fit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members/whānau stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via WDHB when required.</p> <p>During the Covid-19 lockdown phases families were kept informed via skype meetings, phone calls, emails, and a private closed social media page. The social media page allows family/whānau to view what is happening at Resthaven, particularly around activities.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and these are linked to operational plans.</p> <p>A sample of monthly reports to the eight-member trust board showed adequate information to monitor performance is presented which includes financial performance, emerging risks and issues. There has been one new trustee appointed recently. This has been reported to the DHB and Ministry of Health (MoH).</p> <p>The service is managed by the CEO and the GM who has been in the role for 11 years. Both hold qualifications relevant to their role. Responsibilities and accountabilities are defined in a job</p>

		<p>descriptions and individual employment agreements. The management team have knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development.</p> <p>The average occupancy for this facility was 50% at the time of takeover in April 2020. This had increased to 75% by December 2020 with a goal to increase the average occupancy to 85%.</p> <p>Resthaven-on-Burns Street holds contracts with the DHB for rest home, dementia, hospital, respite and palliative care, and a Waikato DHB specific agreement to provide short term rest and relaxation for people after hospital treatments. On the days of audit there were 37 long term residents receiving services under the DHB contract. Nine were assessed as rest home level of care, 15 at hospital level care and there were 13 residents in the dementia wing.</p> <p>Although the facility is certificated for a maximum of 54 beds, currently broken into 18 beds for each service stream, for example, a maximum of 18 in dementia, 18 at rest home (four of these beds are already designated as dual purpose) and 18 at hospital level care, the service provider is considering the decommission of four rooms to gain additional space for bathrooms, storage and areas used by residents.</p> <p>Partial Provisional</p> <p>The service applied to MoH in December 2020 to increase the number of dual service beds from four to 13 by decreasing the number of rest home beds from 18 to nine.</p> <p>Upon observation of the rooms identified, only six were considered to be large enough to accommodate mobility equipment. This would result in a configuration of 12 designated rest home beds, 10 dual purpose beds and 14 designated hospital beds, plus 18 dementia beds.</p> <p>The governance structure was verified as suitable to accommodate an increase in hospital level care at this site. One of the motivations for increasing the number of hospital beds is to ensure that the community has access to quality care that does not require additional 'premium' payments for rooms and to enable residents to stay in the rooms they occupy if their condition deteriorates. This is congruent with the charitable nature and constitution of the trust board.</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</p>	<p>FA</p>	<p>When the GM is absent, the ND carries out all the required clinical duties and another manager carries out the GM's administrative functions under delegated authority. The two CNLs cover each other's absences with support from the ND. Staff reported the current arrangements work well.</p> <p>Partial Provisional</p> <p>The proposed increase to 10 dual purpose beds will not impact on service management. The</p>

to consumers.		organisation already demonstrates an ability to effectively manage hospital level care residents at both its sites.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned and effective quality and risk system that reflects the principles of continuous quality improvement. This includes management and reporting of incidents, infections and restraint events, complaints, audit activities, processes for receiving resident and relative feedback and monitoring staff wellbeing.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. Staff said they were reliably informed about all quality and risk management activities through their monthly meetings and at weekly debriefs that occur in each service wing. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>All actual and potential risks are documented for example, in a range of sighted risk management plans and in the onsite hazard register. Risk is a standing agenda item at board meetings. Resident risks are discussed at regular staff meetings and specifically addressed at health and safety meetings.</p> <p>Satisfaction survey of residents and relatives will not occur for Resthaven-on-Burns Street until after the 12 month anniversary of takeover and at the same time surveys are conducted for the Resthaven Cambridge facility, as these surveys are conducted by an independent external agency.</p> <p>The organisation is a founding member of the Community Trust Care Aotearoa (CTCA) group. This group is continuing to add value to the nine aged related residential care facilities who are members. Benchmarking of quality data across the nine care facilities has been occurring for many years and continues to provide opportunities for learning. For example, the GM noticed that their facility consistently rated a higher numbers of skin tears. Investigation revealed differences in reporting skin tears which has resulted in the group agreeing a standard approach to reporting. The ND is a nominated link nurse between Waikato DHB and the two Resthaven care facilities. A rating of continuous improvement acknowledges these and other activities that benefit resident care. These are described in criterion 1.2.3.1.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to all staff and the board.</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>The CEO and the GM understand essential notification reporting requirements, including for pressure injuries. Two section 31 notifications have been submitted since April 2020, one for a change in board membership and another related to a police call out.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a coaching/professional support review with the education officer within four to six weeks of commencing work.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The education officer is the internal assessor for the programme. Of the 22 Health Care Assistants (HCAs) employed, five are at level 4 of the National Certificate for Health and Wellbeing, eight are at level 3, two are at level 2 and five of the other seven HCAs have commenced the education. Staff working in the dementia care area have either completed or are enrolled in the required Limited Credit Programme –dementia (LCP) The education officer is also validated as the assessor and moderator of this programme.</p> <p>Seven RNS are trained and maintaining their annual competency requirements to undertake interRAI assessments. The GM and the administrator/receptionist are maintaining management access. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Mandatory education for all RNs requires demonstrating understanding and competency with wounds, deteriorating patients, palliative pathways, delirium, vulnerable adults, sepsis, and adherence to frailty guidelines. All RNs are required to complete the venepuncture qualification.</p> <p>The staff interviewed including HCAs, RNs and allied staff, were extremely positive about their work conditions and the level of support they received from their employers. They cited examples of increased learning opportunities, wellbeing initiatives, and improvements to the environment they worked in, excellent communication between staff and management and appreciation that the organisation took immediate action when requested.</p>

		<p>Partial Provisional</p> <p>Recruitment and management of all staff meets safe and best-known employment practices, and legislative and contractual requirements. Orientation and ongoing education are specific to the type of residents cared for and as described above, all staff are supported and encouraged to increase their skills and competence.</p> <p>Initiatives that support staff wellbeing, for example weekly visits by an independent employment support person, and other improvements are contributing to a strong and stable workforce. The addition of six more dual purpose beds is assessed as not having a significant impact on staff management.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>The new operator has implemented a number of changes to staffing allocations with good effect. The process for determining staffing levels and skill mixes is adjusted to meet the changing needs of residents. The GM uses the sector safe staffing guidelines and recommendations from the Grant Thornburn review of Age Care Services report 2010, to determine the number of RN and HCA hours required each day/week for safe and timely provision of care. Staff said they have plenty of hours available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff being readily replaced in any unplanned absence. There is a large work pool available over both sites.</p> <p>There are now two HCAs allocated to work in the dementia unit on the morning and afternoon shift. The hours allocated for the physiotherapy assistant have increased from one hour to five to six hours per week and a music therapist attends to residents in the dementia wing one day a week. Cleaning hours have also been increased.</p> <p>The RNs are now self-rostering. The seven RNs are expected to complete three shifts a week on the floor (triage) and have another 16 hours available for administration/ paperwork (eg, interRAI and other assessments, review of care plans). They are successfully collaborating, so there is at least one 'triage' RN responsive to residents 24 hours a day, seven days a week 24/7 with another one or two RNs often on site. The CNL is on site Monday to Friday and the ND.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. All RNs are maintaining a current first aid certificate so there is at least one staff member on duty with comprehensive first aid/CPR.</p> <p>Partial Provisional</p> <p>The implemented system for staff allocation ensures that staffing levels are adjusted to meet the</p>

		changing needs of residents. However, the provider cannot unequivocally demonstrate this until hospital bed numbers exceed 18 residents. Refer to the corrective action in 1.2.8.1.
<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>Residents' files at Resthaven-on-Burns Street are electronic. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>All electronic records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are admitted to Resthaven-on-Burns Street (Resthaven), when the need for the services provided by Resthaven have been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Residents requiring care in the secure unit, in addition need approval for placement authorised by a specialist, and an activated EPOA in place. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and meet with the GM or CNL. They are also provided with written information about the service and the admission process.</p> <p>All residents' files reviewed of residents in the secure unit had an activated EPOA and specialist's authorisation for placement.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the WDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services, plus an electronically generated transfer form that includes all</p>

<p>coordinated transition, exit, discharge, or transfer from services.</p>		<p>relevant information. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. The organisation's link nurse who works for the WDHB and Resthaven ensures continuity between services.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is 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 an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include 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 is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner should this be required.</p> <p>Medication errors are reported to the RN, CNL and GM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>No change in the medication management system will be required to meet the planned change in the bed status of six beds.</p> <p>Standing orders are not used at Resthaven.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contracting service. The service provided is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in December 2020. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place and expires 30 January 2022.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook and kitchenhands have undertaken internal training with the company in safe food handling.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>The secure unit has access to food twenty-four hours a day, with a well-stocked kitchen in the unit that has a wide range of food items available for residents at any time.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family interviews, residents' weight, and residents' meetings minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>No changes to the kitchen services will be required to meet the request for a change in bed status of six beds.</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>	<p>FA</p>	<p>If a referral is received by Resthaven, 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/ whānau. Examples of this occurring were discussed with the CNL. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission to Resthaven, residents are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation, and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by seven trained interRAI assessors on site. Resthaven completes internal interRAI training for all their RNs, and their trainers can verify competency in interRAI assessment skills.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>All residents' files reviewed in the secure unit had a behaviour management plan that identified the triggers and the management strategies required to manage incidents of challenging behaviours presented.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally/electronically passed on to relevant staff. Residents and family members of residents reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired</p>	<p>FA</p>	<p>Documentation, observations, and interviews verified the provision of care 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 GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the</p>

outcomes.		documentation. Interview with the physiotherapist confirmed Resthaven supports a team approach to ensure resident's physiotherapy needs are met. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme at Resthaven is provided by a recreation coordinator who is mentored by the diversional therapist from the associated facility nearby.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal care plan review every six months. A twenty-four-hour holistic activities plan is included in the files of residents in the secure unit and includes all aspects of the resident's life. This plan addresses the resident's activity needs anytime of the day. Van outings occur as desired; however, with COVID-19 restrictions these have been limited in the past eight months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include exercise sessions, knitting club, bingo, bowls, gardening, music, Maori music sessions, pool, quizzes, visiting entertainers, and daily news updates. A physiotherapist is also on site four hours a day twice a week and implements activity and strength programmes for residents. Activities are well supported by the 'friends of Resthaven community committee'; however, this support has not been available during the COVID-19 restrictions.</p> <p>The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Family members generally interact with the activity's coordinator on a one-to-one basis regarding input over activities in the secure unit. Resident and family members interviewed confirmed satisfaction with the wide range of activities available satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN and CNL.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where</p>

		<p>progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated. Wound management plans were evaluated each time the dressing was changed. Behaviour management plans were reviewed continually and after a change in medication and any challenging event. Residents and family members of residents/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access 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. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow proven to be effective processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>A new chemical supply company is now managing all chemicals and cleaning products and providing hands on training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There were ample supplies of protective clothing and equipment available and staff were observed using this.</p> <p>Partial Provisional</p> <p>An increase in the number of designated dual-purpose beds is not expected to impact on the well-established systems for managing waste and hazardous materials. There are sufficient sluice rooms in the hospital wings including the wing where six rest home beds will be reconfigured as dual purpose.</p>
Standard 1.4.2: Facility Specifications	FA	A current building warrant of fitness (expiry date 06 February 2021) is publicly displayed.

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. Additional storage space for hoists and commodes has been created. There is a sufficient number of safe and suitable hoists on site for the proposed number of hospital level care residents. There is a longer-term plan to install ceiling hoists in hospital and dual purpose bedrooms.</p> <p>External areas are safely maintained and appropriate to the resident groups and setting. These are being upgraded.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>Significant improvements have been made to the internal and external environments. The felling of large trees in front of the facility has created more light and stopped the degradation of asphalt pathways in the car park area. All of the wooden knobs on residents' doors are being replaced with easy to clean hygienic metal door handles. More corridor safety rails are installed. The reception area has been upgraded, 20 new mattresses were purchased, a dangerous shower room in the wing identified as suitable for six dual purpose beds has been decommissioned and another shower room upgraded. A new call bell system is ready for installation throughout the facility, and cameras (CCTV) are being installed outside the buildings. Upgrading to the interior of the dementia wing has commenced and refurbishment of the outside areas and gardens accessible for residents in this wing is underway.</p> <p>Partial provisional</p> <p>Significant improvements to all inside and outside areas have already occurred. The work already completed and underway in the wing identified for six dual purpose rooms makes the physical environment appropriate and accessible for hospital level care.</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</p>	<p>PA Low</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 14 toilets and nine showers for resident use. One bathroom in the wing which is intended for dual purpose use has been upgraded, one unsafe bathroom has been decommissioned and another is flagged for upgrading. The Covid-19 lock down has delayed building works by six months. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment and accessories are available to promote residents' independence, for example, full swing hoists and standing hoists.</p>

<p>assistance with personal hygiene requirements.</p>		<p>Partial provisional</p> <p>There is one fully accessible bathroom in the wing that is intended to have six rooms designated as dual purpose. Another bathroom in that wing is flagged for upgrade. This needs completing.</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>All bedrooms are for single occupancy. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs, and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> <p>Partial provisional.</p> <p>The six rooms identified for reconfiguration to dual purpose, are all of suitable size. These had originally been fitted out as double rooms. All rooms have double doors which afford sufficient width to accommodate hoists, other mobility equipment and bed transfer if required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. There are four dining rooms and four lounge areas located within easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>Partial provisional</p> <p>There is a choice of spacious lounges and dining areas within close proximity to the wing identified for six dual purpose beds.</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>CI</p>	<p>Laundry continues to be undertaken off site by a contracted provider. Only a small amount of personal laundry is undertaken on site (for example, for residents in the dementia unit). All staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and the safe handling of soiled linen.</p> <p>Residents and family members interviewed reported satisfaction with the laundry system and said their clothes are cared for and returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training as confirmed in interview with cleaning staff and review of their training records. Chemicals were stored in a designated and lockable room and where needed, chemicals were being decanted into suitable</p>

		<p>and clearly labelled containers.</p> <p>The effectiveness of cleaning and laundry processes are monitored through resident and relative feedback and the internal audit programme. All areas of the facility were observed to be clean and staff demonstrated that the daily practices occurring ensure maintenance of hygienic, reliable and regular cleaning throughout the home.</p> <p>Staff described significant improvements with the cleaning systems which have benefited themselves and residents.</p> <p>Partial Provisional</p> <p>The current cleaning and laundry systems can easily accommodate a potential increase of six more hospital level care residents.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.</p> <p>The fire evacuation plan was originally approved by the New Zealand Fire Service in 1998 and reviewed in 2006. There have been no structural changes to the building which require any change to the current fire evacuation scheme, although an external fire expert recently contracted has advised that the fire doors in place no longer meets the amended fire regulations. This has necessitated a change to the way fire drills are conducted, for example, staff cannot rely on the presence of fire retardant 'cells' and must complete a full evacuation. Trial fire evacuations take place six-monthly with a copy sent to the Fire and Emergency Services New Zealand (FENZ). The most recent fire drill occurred on 03 February 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for what could be a maximum of 54 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region.</p> <p>Staff described being able to situate a generator on site within 10 minutes, as happened during the twelve-hour mains supply failure in the town seven years ago.</p> <p>The battery powered emergency lighting system is regularly tested. A new call bell system for the entire facility has been approved for purchase due to the unreliability of the current system. Evidence was sighted that installation is confirmed for the week beginning 08 March 2021.</p>

		<p>Security is maintained by staff conducting door and window checks three times between 5pm and 7am each day. New swipe card access has been installed into the main entry and the secure wing. The organisation is also installing external cameras (CCTV) pursuant to a security breach in January 2021.</p> <p>Partial provisional</p> <p>The current systems for fire, emergency and security ensure resident and staff safety and will not be impacted by the proposed reconfiguration of beds.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden or small patio areas. Heating is provided by electricity in residents' rooms in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>Partial Provisional</p> <p>The six rooms identified for reconfiguration as dual-purpose rooms have large sized windows and/or ranch sliders that allow in plenty of natural light and ventilation. There are individual heaters in each room.</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>Resthaven provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the infection control coordinator (ICC), GM, ND, CNL and external infection control advisors. The infection control programme and manual are reviewed annually.</p> <p>The RN at Resthaven is the designated infection control champion, who reports directly to the ICC whose role and responsibilities are defined in a job description and to the CNL. Infection control matters, including surveillance results, are reported monthly to the ICC, and tabled at the quality/risk/staff meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities, in addition to other nationwide aged care facilities.</p> <p>The organisation's GM is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past</p>

		<p>48 hours not to enter the facility. With the present COVID-19 alert, all visitors are asked to fill in a health questionnaire before entering. The contents of the form are reviewed by the administrator prior to entry approval being given. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p> <p>With the recent COVID-19 alerts, CTCA have developed a pandemic management document. This is a comprehensive document that identifies the actions staff are to take during the identified alert levels. It also includes actions to be taken afterhours and at weekends in the event of a change in alert levels. This is a working document, which gives clear guidelines that everyone can follow regarding how the facility will function and the restrictions to be imposed.</p> <p>A change in bed status being considered in the partial provisional audit, will not require any changes to the infection control programme at Resthaven.</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 ICC has appropriate skills, knowledge, and qualifications for the role, and oversees two sites. The ICC is assisted at Resthaven by an infection control champion, who is responsible for managing the surveillance of infections daily. The infection control champion has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the WDHb are available and expert advice from two contracted external advisory companies is available if additional support/information is required. The coordinator and champion have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC, infection control champion, and CNL 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 organisation. These policies and</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC and the infection control champion. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent COVID-19 case in the community.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Resthaven is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control champion, ICC and CNL review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers and externally with other aged care providers.</p> <p>A good supply of personal protective equipment is available. Resthaven has processes in place to manage the risks imposed by COVID-19.</p>
Standard 2.1.1: Restraint minimisation	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>CNL/restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the days of audit, one resident was using a restraint and one resident was using an enabler, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident from onsite observations, interviews with all levels of staff and review of resident files and staff and management meeting minutes.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The CNL/restraint coordinator, GP and another RN are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was seen in the file of the sole resident requiring a bed rail as a restraint. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the standard. An RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. Families confirmed their involvement. The general practitioner makes the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. A completed assessment was sighted in the records of the resident with a bed rail in place as to ensure the resident's safety and security.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members for example, the use of sensor mats, low beds and placing 'landing strips'/'fall out' mattresses on the floor beside the bed.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe.</p>

		<p>Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>An electronic restraint register is maintained and updated as required. The register reviewed documented the residents currently using a restraint and enabler. This contained sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at six monthly restraint evaluations. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	CI	<p>The organisation undertakes an annual review of all restraint use which includes all the requirements of this standard. Documentation of the review included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. The annual review also considered whether any changes to policies, guidelines, education or processes were indicated. Restraint activity and individual use of restraint use is reported at staff meetings. Data reviewed, minutes and interviews with the GM and CNL confirmed that the use of restraint has been reduced from three to one since April 2020.</p> <p>The organisation has succeeded in preventing and reducing the use of restraint. The previous rating of continuous improvement is ongoing.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	The provider demonstrates that they have proven and effective systems for determining and implementing safe staffing levels which respond to resident’s acuity and needs. The change to the way RNs are rostered as described above, means that there are often more RNs on site 24 hours a day, seven days a week.	The provider will not be able to demonstrate safe and suitable staffing levels until the number of hospital level care residents exceeds 18 and up to a maximum of 24.	<p>Ensure there are sufficient suitably qualified and skilled RNs and HCAs available on all shifts to meet the needs of the number of frail elderly/hospital level care residents.</p> <p>Prior to occupancy days</p>
Criterion 1.4.3.1	PA Low	There are currently four accessible and safe bathrooms and toilets for a potential 18 level care residents. One of the	There are not enough safe and	Ensure there are sufficient safe and

<p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>		<p>three bathrooms in Pohutukawa wing (where six additional dual-purpose beds are proposed) has been upgraded. One bathroom has been decommissioned and another is tagged for upgrade. There is large wet area space in an adjacent wing which is currently being used as a hair dressing salon. The plan is to upgrade this as an additional accessible bathroom for hospital level care residents.</p> <p>There are sufficient toilets available for residents, visitors and staff on site.</p>	<p>accessible showers in close proximity to the six bedrooms proposed for hospital level care.</p>	<p>accessible bathrooms for hospital level care residents.</p> <p>Prior to occupancy days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>The CTCA is a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not-for-profit organisations. Members of the CTCA group have experienced significant improvements in their governance and business operations which leads to improving resident care. The sharing of innovative ideas and strategies across the facilities, cost savings in bulk purchasing for goods, power and insurance, same banking and increased borrowing capacity, shared staff and board training and peer support for RNs and managers is of benefit to all, as evidenced in the reports generated across the group and through interviews.</p> <p>This group has elected its own governance</p>	<p>Residents and their families are immediately updated and informed about outcomes from specialist appointments at Waikato Hospital as a result of RNs being able to access the DHB based patient information portal. This has significantly reduced unnecessary delays in beginning treatment or ordering further tests and follow up. The DHB have evaluated this as effective and authorised access is continuing.</p> <p>The collegiality being built</p>

		<p>subcommittee. Meetings between the DHB and the chairperson of the governance committee resulted in both facilities operated by the Cambridge Resthaven Trust being able to access the DHB based patient information portal. This allows registered nursing staff to immediately access information about their residents who had been seen by medical staff at Waikato Hospital. Staff can then immediately initiate prescribed treatments and/or plan and arrange follow up appointments ordered by specialists and keep family informed about progress.</p> <p>The ND is employed part time in older person's services at the local (Waikato) hospital. This person is nominated as a 'link nurse' between the hospital and both aged care facilities operated by Cambridge Resthaven Trust. The link nurse is validated as a preceptor for new nurse graduates which enables the provider to continue its engagement in the Nursing Entry to Practice (NETP) Programme. The ND is also credentialed to supervise and validate RNs who carry out venepuncture.</p>	<p>between all governing bodies and facility managers in the CTCA group is providing valuable peer support, generating innovation and ideas and providing strategic direction for all members. This was evidenced by review of the group reports, and interviews with the CEO and the GM.</p> <p>The group are regularly holding shared training sessions for care staff to attend which is cost efficient, provides more training opportunities, and has fostered the participants' commitment to progress and achieve higher levels of education. The cost benefits for the group are measured in savings gained from group discounts for insurance, bank fees, power supply and bulk purchasing for essential supplies such as continence products, chemicals and food supplies.</p> <p>Having registered nurses competent and credentialed to carry out venepuncture, prevents residents having to go offsite for blood tests and speeds up getting results from laboratory testing.</p>
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<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>CI</p>	<p>Laundry is undertaken off site by a contracted provider, except for the personal laundry of people in the dementia wing. Previously staff had to leave the unit at night to complete laundry tasks. The washing machine is relocated to the dementia wing now. Additionally, the organisation has purchased the equipment required to tag all residents clothing so there is no cost for this to the resident or their families.</p> <p>The effectiveness of cleaning and laundry processes are monitored through resident and relative feedback and the internal audit programme. All areas of the facility were observed to be clean and staff demonstrated that the daily practices occurring ensure maintenance of hygienic, reliable and regular cleaning throughout the home.</p> <p>Chemicals are now being sourced from a different supplier. All door handles on residents' rooms are being replaced from wood to metal handles which are more hygienic and easier to clean. The cleaners have been allocated more hours of work. One cleaner is on site for five hours a day seven days a week and there is a second cleaner rostered on for a full shift one day a week.</p> <p>A new floor cleaning system which reduces the amount of water and chemicals required, is implemented.</p>	<p>Staff and residents are provided with a safer environment through reducing the amount of chemicals used for cleaning. The increase in cleaning hours enables deeper cleaning of resident areas.</p> <p>Staff in the dementia wing no longer have to leave the unit to carry out laundry tasks.</p>
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all</p>	<p>CI</p>	<p>Interview with family, the restraint coordinator, review of all restraint documentation and visual observation</p>	<p>The use of restraint has continued to diminish due to the procurement and use of</p>

restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.		confirmed that all restraint practice is safe, meets the requirements and that suitable alternatives to restraint are in place. The service has been conducting frequent reviews of restraint use and other related matters. One of the outcomes from these reviews was a planned focus on reducing overall restraint use. This has been successful.	alternatives, such as low beds and roll out mattresses.
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End of the report.