

Te Hopai Trust Board - Te Hopai Home and Hospital

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Te Hopai Trust Board
Premises audited:	Te Hopai Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 February 2021 End date: 5 February 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	149

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Te Hopai is owned by a Trust and provides rest home, hospital (medical and geriatric) and dementia level care for up to 151 residents. There were 149 residents on the day of the audit.

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

Te Hopai has a general manager who is responsible for operational management of the service. She is supported by a management team including a clinical manager, a quality manager, a human resource manager, a managing trustee (a board member) and clinical managers in the rest home, hospital and dementia unit. There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through the quality and risk management programme. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Residents and family members interviewed spoke highly of the services provided at Te Hopai.

This audit has identified no areas requiring improvement.

The service has exceeded the required standard around: good practice, communication, activities and infection control.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

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

Policies and procedures adhere with the requirements of the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

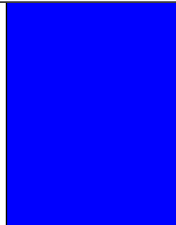
Te Hopai has a current business plan and a quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme, benchmarking with similar services and a health and safety programme that includes (but not limited to) hazard management. Quality data is used to improve resident outcomes.

Quality information is reported to a variety of facility meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings.

Te Hopai has job descriptions for all positions that include the role and responsibilities of the position. There is an in-service training programme that has been implemented and staff are supported to undertake external training. The staff orientation programme is comprehensive and now allows staff to achieve NZQA standards. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing levels. Staff, residents and family members reported staffing levels are sufficient to meet resident needs. Staffing can be adjusted to meet current residents' needs and acuity.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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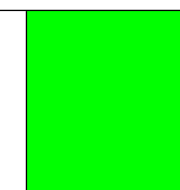
Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process.

The diversional therapists and activity coordinators provide an activity programme for the residents in the rest home, hospital and dementia care units. The programme is varied, interesting and meets the recreational needs and preferences of the consumer group.

There are policies and processes that describe medication management. Indications for use are clearly documented. Competency assessments for self-medicating residents are in place should there be any residents self-medicating (there were none at the time of audit).

An external contractor is contracted to provide the food service. All meals are prepared on site and the kitchen is well equipped. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There has been dietitian review of the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored securely throughout the facility. Appropriate policies are available along with product safety charts. Rooms are individualised and uncluttered. Resident rooms are spacious.

External areas are safe and well maintained. The dementia unit and outdoor area are spacious, light and safe. The facility has a van available for transportation of residents. Those transporting residents hold a current first aid certificate. The building holds a current warrant of fitness and a preventative and reactive maintenance programme is implemented.


There are spacious lounges within each area. There are adequate toilets and showers for the client group. All resident rooms throughout the facility have full ensuite. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

All key staff hold a current first aid certificate. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency food supplies are held on site and a large supply of water.

Cleaning and laundry services are completed on site and are well monitored through the internal auditing system.

The facility is well laid out and the temperature is comfortable and constant. Residents and family interviewed were very satisfied with the environment.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there were no restraints and 15 enablers in place. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control coordinator is a registered nurse. The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	0	0	0	0
Criteria	4	89	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are being implemented that align with the requirements of the Code. Families and residents are provided with information on admission, which includes information about the Code. Service information has been documented in a variety of languages to reflect the cultural diversity of the client group. Staff receive training about resident rights at orientation and as part of the annual in-service programme.</p> <p>Discussions with staff including: eight caregivers, four registered nurses (RN), three diversional therapists, one housekeeper, one chef, one laundry person and one maintenance person, confirmed their familiarity with the Code.</p> <p>Four residents (two rest home and two hospital) and nine relatives (three hospital, two rest home and four dementia care) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are</p>	FA	<p>Te Hopai Home and Hospital has policies and procedures relating to informed consent and advanced directives. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The resident files reviewed included signed multipurpose informed consent forms for information sharing including taking of photographs, collecting and releasing health information and outings as part of the admission process and</p>

<p>provided with the information they need to make informed choices and give informed consent.</p>		<p>agreement. Admission agreements sighted were signed by the resident (where appropriate), nominated representative/EPOA.</p> <p>Discussion with relatives identified that the service actively involves them in decisions that affect their relatives' lives. The resident files reviewed had completed resuscitation documentation either signed by the resident in consultation with the GP or following discussion with the enacted enduring power of attorney the GP had signed a 'not for resuscitation' order. Resuscitation information was easily accessible in the residents' hard copy file. Resuscitation has been reviewed at least annually.</p> <p>The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. The caregivers interviewed could easily describe when residents give consent during daily cares. Registered nurses had a good understanding of informed consent and reported this is reviewed at least annually.</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>	<p>FA</p>	<p>Advocacy information is part of the service entry package and is on display on notice boards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file. Te Hopai Home and Hospital has two dedicated facility advocates displayed at the facility entrance, a board trustee visits monthly and attends residents' meetings twice yearly, acting as resident advocate. Interviews with residents confirmed that they are aware of their right to access advocacy. There is also an advocate who visits three mornings a week and is available to talk with residents.</p> <p>Interviews with family members identified that the service provides opportunities for the family/EPOA to be involved in decisions. The resident file includes information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, (for example, attending local community events and cafes). Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p> <p>Dementia: There are volunteers who drive the van for outings. High school students read to the residents, look through travel journals, walk with residents, and spend one-on-one time with residents.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>There is an online complaint register that includes written and verbal complaints, dates and actions taken. There were seven complaints during 2019, four in 2020 and no complaints year to date for 2021. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides an information pack to prospective residents, that includes information about the Code, complaints, and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Monthly resident meetings provide the opportunity to raise concerns and an annual residents/relatives survey is completed.</p> <p>Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</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>A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents and relatives interviewed confirmed that staff treat residents with respect. Staff could describe definitions around abuse and neglect that aligned with policy.</p> <p>The 2020 satisfaction survey identified 94.7% of residents were happy with privacy. Contact details of spiritual/religious advisors are available. Staff education and training on abuse and neglect has been provided, last occurring in March and April 2020.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And</p>	<p>FA</p>	<p>The Māori health plan for the organisation references local Māori health care providers regionally within New Zealand and provides recognition of Māori values and beliefs. The service has a link with Whānau Care</p>

<p>Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Services and if required refer residents to the Capital and Coast DHB Māori Health Unit Services. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. The service has commenced a Māori roopu to discuss issues pertaining to Māori. The first meeting has been held. The group aims to develop a process and plan to build trust and respect through learning across culture.</p> <p>The cultural component of care plans were documented, including one file for a resident who identifies as Māori. The resident was interviewed, and they expressed their overall happiness with the service and the staff. A selection of staff have learned basic te reo Māori for a resident in the dementia unit with strong affiliations with their culture. Staff interviewed described lots of activity resources around Māori culture including singing waiata and having music and movies as resources. Māori cultural preferences of the residents were threaded throughout the care plans reviewed.</p> <p>Discussion with families confirmed that they are regularly involved.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans.</p> <p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. There are multi-cultural staff available and interviews with residents confirmed that cultural values and beliefs were considered and discussed during preparation and review of the care plan. Te Hopai retains its rainbow certification.</p> <p>Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</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>Staff job descriptions include responsibilities of the position. Interviews with staff and management confirmed their awareness of professional boundaries.</p> <p>Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. During interviews, caregivers could describe how they build a supportive relationship with each resident.</p>
<p>Standard 1.1.8: Good</p>	CI	<p>The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A</p>

<p>Practice</p> <p>Consumers receive services of an appropriate standard.</p>		<p>formal quality improvement programme has been developed, which includes identification through to sign off. The service employs a skilled quality manager with quality and auditing qualifications. Continuous improvement and quality projects include literature reviews to ensure that all practice and any changes and improvements are evidenced-based and promote best practice. Quality and management meeting minutes demonstrate numerous examples of best practice. The service has exceeded the required standard around good practice.</p> <p>Care planning is holistic and integrated, and documents are continually reviewed and improved to allow improvements in care, support and integration.</p> <p>Training plans are in place. Staff development occurs by way of education and in-service training. Careerforce training and in-service training occur. Staff are encouraged and supported to complete external courses and qualifications. The manager undertakes international research trips to research best practice in other settings.</p> <p>Te Hopai was awarded a continuous improvement at the last certification audit around low usage of antibiotics. The infection control facilitator continues to monitor the use of antibiotics and has followed the USA centre for disease control “Core Elements of Antibiotic Stewardship for Nursing Homes”. The service wanted to identify the correct antibiotic was used for the correct length of time and that all other options had been exhausted. A report was developed which contained four process measures and three outcome measures. This enabled the service to reduce empirical therapy to pathogen directed therapy, ensuring the length of antibiotic treatment is therapeutic.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in ongoing care and regular contacts are maintained with family including; if an incident/accident, care/medical issues or complaints arise. This was confirmed in interviews with staff and families, review of resident’s files and from a sample of incident forms. The family are notified of GP visits and if unable to attend, they are informed of all the changes.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. The service has multi-cultured staff and residents; registered nurses and caregivers described being able to interpret for some residents when needed.</p> <p>The information pack and admission agreement included payment for items not included in the services. A site-specific introduction to the dementia unit providing information for family, friends and visitors to the facility is provided.</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>	<p>FA</p>	<p>Te Hopai Home and Hospital provides hospital (medical and geriatric), rest home and dementia level care for up to 151 residents across four units. On the day of audit there were a total of 149 residents. There were 111 at hospital level including two respite, 22 at rest home level and 16 residents in the dementia unit, including two respite.</p> <p>The Kowhai dementia unit has 16 beds and was full on audit day with all residents on the age-related care contract (ARRC).</p> <p>The 'Hospital' is a 41-bed dual-service unit (hospital and rest home). On the day of the audit there were 40 residents – 37 at hospital level care and three rest home level residents.</p> <p>The Owen Street building is two levels and all beds in this area are dual-purpose.</p> <p>Level 1 has 21 beds. On audit day, the unit was full. All 21 residents were at hospital level.</p> <p>Level 2 has 26 beds and was also full-on audit day. Twenty-three were hospital level care and three were rest home level care.</p> <p>The rest home unit has 47 dual-service beds. On the day of the audit there were 46 residents, there were 16 rest home residents and 30 hospital level care.</p> <p>Te Hopai is owned and operated by a Trust Board with a high level of appropriate skills and expertise. The managing trustee oversees the general manager and provides a liaison point between the general manager and the board. He reported a very high level of satisfaction with the general manager. The organisation chart describes the general manager who has been in the position for 15 years is supported by a clinical manager, a quality and training manager, a rest home care manager and a dementia care manager.</p> <p>There is a business plan and a quality plan documented. The quality plan was updated during 2020 to reflect Covid-19. Quality goals for 2020 have a documented review and updates have been provided to the board and staff through quarterly reports. A selection of quality goals have transferred over to 2021 due to Covid-19. This has included: improving communication and also oral health. The Māori project linkages have continued into 2021 as has anti-microbial stewardship and the cognitive stimulation project, due to the successes of 2020.</p> <p>The management team have maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures</p>	<p>FA</p>	<p>During a temporary absence, the clinical manager undertakes the role of manager. She has extensive aged care experience. She is supported by the managing trustee on behalf of the board, the quality and training manager and the rest home and dementia care managers.</p>

<p>the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<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>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance are reported across facility meetings. Discussions with the managers (general manager, human recourse manager, quality manager, and three clinical managers/RN and staff reflected their involvement in quality and risk management processes. Resident and family meetings are monthly with evidence of their active participation.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed every two years and as needed. Clinical guidelines are in place to assist care staff.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which are utilised for service improvements. Internal audits are completed as per the audit schedule. A monthly quality report is documented and communicated to staff in meetings and on staff notice boards. Corrective action plans are implemented where results reflect opportunities for improvements. Corrective actions are signed off when implemented.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. There is a 2020-2021 quality programme which has been updated to reflect pandemic management and Covid-19. There is a set of health and safety policies which have been reviewed and approved by a health and safety consultant. The general manager chairs the health and safety meeting; all representatives have completed online health and safety training. The Board have completed due diligence training (2018).</p> <p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. All new staff and contractors undergo a health and safety orientation programme with evidence sighted of staff and contractors participating in annual health and safety refresher programmes.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Detailed review of falls incidents has resulted</p>

		<p>to improved documentation around residents at more risk of falling and this has reduced falls in this group.</p> <p>Fall prevention - Flowers on resident room doors indicate level of fall risk to assist staff to prioritise answering of call bells.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. A review of 15 incident forms from across all areas demonstrated that individual incident reports are completed for each incident/accident, with immediate action noted and any follow-up action required, and family have been notified. The data is linked to the internal benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings and all other facility meetings reflected discussion of incidents, trends and corrective actions required.</p> <p>A review of incident trends showed that an action plan has been completed when there has been a rise adverse events (including falls and skin tears as examples). Urinary tract infections have documented a rise but remained below the service's upper limit; the service has reviewed this trend and ensured that all interventions are in place to ensure best practice.</p> <p>Discussions with service management confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. One notification has been made since the previous audit for an unstageable pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The service maintains a register of registered nurses' and allied health providers' practising certificates. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Eleven staff files were reviewed including four caregivers, four registered nurses, two diversional therapists and one unit coordinator. All contained evidence of appropriate human resource management practices. All files had up-to-date performance appraisals.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (for example, RN, support staff) and includes documented competencies. The programme includes significant dementia components, which have been reviewed and are now NZQA approved. Completed orientations were present in all staff files sampled. Staff interviewed could describe the orientation process and stated that they believed new staff were very well orientated to the service.</p> <p>The human resource manager oversees education whilst the service recruits for a training coordinator. There</p>

		<p>is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence in RN staff files of attendance at the RN training days, DHB training, postgraduate education opportunities, hospice training and other external training. A journal club for registered nurses is facilitated by the clinical manager. The service supports Careerforce training for staff; and at the time of audit there were 10 staff with level two, 18 with level three and 38 at level four (some have more than one level).</p> <p>A competency programme is in place. Core competencies are completed annually or bi-annually depending on requirements. The quality and training manager maintains a comprehensive database to ensure competencies are maintained. There is a first aid trained staff member on duty for each shift and annual medication competencies are up to date.</p> <p>There are 13 staff who work in the dementia unit. All of the staff including the diversional therapist have completed the required dementia unit standards.</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>FA</p>	<p>There is a roster for each area that aligns with contractual requirements and includes skill mixes. The care managers, clinical manager and general manager reported that the board supports high standards of care and funds staffing to ensure this. This was confirmed by the managing trustee.</p> <p>Several of the management team, including the general manager, education coordinators, clinical manager, rest home and dementia care managers and the quality and training manager are registered nurses.</p> <p>In Owen Street Level one (21 residents of 21 beds - all were hospital level) there is one registered nurse on morning shift and one on afternoon shift.</p> <p>The caregiver roster includes: AM; two full and two short shifts, PM; two full and one short shift and two at night.</p> <p>In Owen Street level two (26 residents of 26 beds - Twenty-three were hospital level care and three were rest home level care). There is an RN on morning shift and one on afternoon shift. One registered nurse covers both Owen Street wings overnight and is based on the floor with the highest acuity at that time.</p> <p>The caregiver roster includes: AM; three full shifts and four short shifts (two ending at 11 am and two at 1 pm). PM; two full and two short shifts and two on at night.</p> <p>In the hospital, (40 residents in the 41-bed unit - There were 37 residents at hospital level care and three rest home level residents). There are two registered nurses on morning shift, one on afternoon shift and one on night shift.</p> <p>The caregiver roster includes: AM; four full shifts and six short shifts. PM: two long shift and three short shifts (there are three staff on duty until 11 pm due to the varying short shift times), and two at night.</p> <p>In the dementia unit, (16 residents in the 16-bed unit), there is the care manager (registered nurse) on duty</p>

		<p>during the day, during the week.</p> <p>The caregiver roster includes: AM one full shift and two short shifts plus the diversional therapist. PM; two full shifts plus a lounge 'watch' 4.30 pm – 7.30 pm. There is one caregiver at night.</p> <p>In the rest home, (46 residents in the 47- bed unit - There were 16 rest home residents and 30 hospital level care). There are two registered nurses and a care manager (registered nurse) on morning shift, and one on afternoon shift and one on night shift.</p> <p>The caregiver roster includes: AM; four full shifts and five short shifts, PM; two full and one short shift plus a 'lounge watch' 3pm -8pm. There is one caregiver at night.</p> <p>Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier and resident acuity levels were higher.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident records sampled at Te Hopai contain adequate and appropriate information relevant to the service. Residents entering the service have all relevant information recorded within 24 hours into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Support plans and notes are legible and where necessary signed (and dated) by the registered nurse.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation. Individual resident files demonstrate service integration.</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>There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. Te Hopai communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whānau are provided with associated information such as the Code, complaints information, advocacy, and admission agreement. Family and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for all thirteen resident files sampled.</p>
Standard 1.3.10: Transition,	FA	The service has transfer and discharge procedures. The procedures include a transfer/discharge form, and

<p>Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>the completed form is placed on file and retained as part of the archived resident records.</p> <p>Registered nurses were able to describe (and present) the information forwarded when a resident is transferred. The information was noted to be complete, appropriate, and fully documented and communicated to support health care staff to meet the needs of the transferring resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are medication policies and procedures in place that meet legislative requirements. All clinical staff who administer medications (RNs and senior caregivers) are competency assessed and attend annual medication education provided by senior RNs. The RNs attend syringe driver training and annual refresher at the hospice. The pharmacy provides the blister packs, and these are checked by two RNs on delivery. Discrepancies are reported back to the supplier. Standing orders were in place and reviewed annually by the GP. Stock medications are available in two of the five medication rooms and expiry dates are monitored. Each unit has a medication room and medication fridge. The medication fridge temperatures were within an acceptable range. The five treatment rooms had recorded temperatures. Each area has a locked medication trolley kept in a locked treatment room or cupboard within their unit. All eye drops were dated on opening.</p> <p>Twenty-six medication charts sampled (ten hospital, eight dementia, eight rest home) identified that the GP/NP had seen and reviewed the resident three-monthly and the medication chart was signed.</p> <p>The use of 'as required' (PRN) medications are monitored and signed with times when administered. All PRN medications and insulin for residents in the dementia unit are administered by an RN. Staff are required to demonstrate that alternative strategies have been used prior to the use of PRN medication for agitation/aggressiveness. All medication charts sampled had photo identification and allergies/adverse reactions documented. All medication charts sampled met legislative requirements.</p> <p>Medication rounds sighted demonstrated appropriate practice. Administration records had all prescribed medications signed as administered.</p> <p>The medication charts evidenced very low usage of regular and 'as required' antipsychotic medications and the residents (where appropriate) were on reducing doses of antipsychotic medications (link 1.1.8.1).</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</p>	<p>FA</p>	<p>A catering company have the contract to provide meals for the residents at Te Hopai home and hospital. All food is prepared and cooked on the premises. There is a rotational weekly winter and summer menu that has been reviewed by the dietitian (November 2020). There is a chef/site manager, three other chefs including one in training and three catering assistants. The main meal is at midday and offers a choice of two main meals. The chef receives a dietary requirement form for each new resident admission with documented nutritional needs, likes and dislikes. The chef also receives a daily updated list with individual resident meal choices for the day and specific dietary requirements and any residents with weight loss. Vegetarian, gluten</p>

<p>service is a component of service delivery.</p>		<p>free and modified/soft/pureed meals are provided. Hot boxes with individual meal trays and heat lids are delivered to three-unit serveries and a chef accompanies the meals to serve in the remaining two wings. Temperature monitoring is carried out on hot food daily. The walk-in chiller, fridges, freezer and dishwasher temperatures are monitored daily. Chemicals are stored safely.</p> <p>The three chefs are fully qualified. The assistant chef is in training. All kitchen staff have been trained in safe food handling and chemical safety. The Food control plan was verified January 2021.</p> <p>Residents and relatives were complimentary of the meals and food services.</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>The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to potential residents is recorded and communicated to the resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.</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>The interRAI assessment tool was completed within expected timeframes in all resident files sampled. Fourteen registered nurses have completed interRAI training. Assessments are conducted in an appropriate and private manner. Assessment process and the outcomes are communicated to staff at shift handovers, progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process.</p> <p>The assessment tools link to the individual care plans. Residents' LTCPs link closely to the interRAI assessments.</p> <p>Families and residents interviewed confirmed their involvement in assessment processes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	<p>FA</p>	<p>The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Long-term care plans sampled were reviewed and updated in a timely manner. Interventions were sufficiently detailed to address the desired outcome/goal. Short-term care plans are in use for changes in health status and include interventions and date of resolution were evident in the sampled files. Examples sighted are cares required for wounds, infections, and weight loss. Residents and families confirmed they are involved in</p>

service delivery.		<p>the development of long-term care plans.</p> <p>Dementia – care plans were detailed, individualised and contained descriptions of behaviours, identified triggers and individualised de-escalation/ diversion techniques. Challenging behaviours and interRAI triggers were identified throughout the care plan.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Needs are assessed using pre-admission documentation, doctor’s notes, and the assessment tools, which are completed by a registered nurse. Care plans reviewed were goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status as evidenced in twelve of thirteen files sampled (one resident was a new admission and did not yet require review). Residents have the option of choosing the frequency of showering and linen changes including daily assistance.</p> <p>All staff reported that there are adequate continence supplies and dressing supplies. The registered nurses interviewed described the referral process and related form should they require assistance, for example, from a wound specialist, continence nurse, speech language therapist and the hospice.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs.</p> <p>There were fourteen skin tears, three venous ulcers, four pressure injuries, three surgical wounds and other conditions such as rashes documented in the wound register. There were no residents with wounds in the dementia unit. A number were left on the register for a period after healing to encourage close observation. Comprehensive wound assessments are carried out with each dressing change and include monitoring the size of the wound, condition of the surrounding skin, exudate, and odour, signs of infection, type and frequency of dressing changes. Wound dressing changes are also recorded in the resident progress notes. The RN assesses and evaluates all wounds. There is access to wound care nurses and specialists as required. Wound care education has been provided.</p> <p>Food and dietary requirements are completed on admission and reviewed six monthly or earlier if required. Residents are weighed monthly. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. The effectiveness of ‘as required’ pain relief is documented in the electronic medicine system and progress notes. Pain management is reviewed at the resident reviews with the multi-disciplinary team (MDT) team.</p> <p>Residents and family members interviewed confirmed the current care and treatments they and their family members are receiving meet their needs.</p> <p>All falls are reported on the resident accident/incident form and reported to the registered nurse and care</p>

		<p>manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral is initiated as required.</p> <p>Monitoring charts such as blood sugar level monitoring, behaviour monitoring, weight charts and effectiveness of pain relief were evidenced in use.</p> <p>The psycho-geriatrician was involved with dementia residents. The nurse practitioner has a special interest in mental health and dementia.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>Te Hopai Home and hospital has three diversional therapists and two activity coordinators who have extensive experience. They are supported by a group of long-term dedicated volunteers (approximately 30) so enabling the provision of extensive one to one therapy. There is a separate programme for each area (hospital, rest home, dementia and the Owen dual-purpose unit). In total, staff work 138.5 hours per week running a programme for seven days a week in the dementia unit and for five days a week in the other three areas.</p> <p>The team meets weekly to plan the programme. Each unit has specific programme activities that are appropriate to the resident's physical and cognitive needs. The programme is proactive and flexible to respond to residents' needs. An example is the development of the new outdoor area in the dementia unit. Shared activities within the departments are opened to all residents (as appropriate). There is one-on-one time with residents evidenced in the individual progress notes.</p> <p>A community relationship is in place with local kindergartens and schools and a poetry group. Volunteers visit throughout the week and spend time with residents including playing bowls, reading and bringing pets to visit. There are a number of different entertainers performing each week. The community van and red van (a van used for one- on-one outings for residents) are used for outings.</p> <p>An activities staff member contacts each resident and their family/whānau within 24 hours of admission. Their activity assessment and lifestyle care plan are developed within three weeks of admission in consultation with the resident/family/whānau. Since the introduction of electronic clinical records, reporting is ongoing, recording residents' attendance and participation.</p> <p>Notices of upcoming activities are posted around the facility and delivered to residents' rooms. A daily notice is sent to staff via electronic clinical records to notify them of the day's activities, so they can remind residents/have them ready and in the appropriate area. Feedback on the programme is received through monthly resident meetings and regular surveys. Residents interviewed stated they enjoyed the activities, entertainers and outings provided.</p> <p>There are two diversional therapists who work across seven days in the Kowhai (dementia) unit. Social profiles are completed by family on admission, and special interests and information is incorporated in the</p>

		<p>care plan. Progress notes are completed daily as residents attend various activities and outings. The seasonal activity planner contains a range of activities is planned which are meaningful to the residents and include past interests as much as possible. The diversional therapist interviewed described aligning residents with common interests during activities. Activities are often spontaneous depending on the general theme of the day. Special occasions and celebrations are celebrated. Routine activities include regular church services, daily exercises, music/dancing, group games, gardening (weather permitting) art and crafts and twice weekly van outings. The diversional therapist interviewed reported volunteers assist with activities such as driving the van for outings, one-on-one chats, reading and reminiscing with journals. The caregivers and the diversional therapist described accommodation of specific cultures such as Māori and European cultures by the use of music, movies, and documentaries around resident specific cultures and backgrounds. Residents can participate as a group or individually with the use of iPads.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident files sampled demonstrated that the long-term care plans were documented and reviewed at least six monthly or as changes occur. Six monthly MDT reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the residents' care. The interventions in both long-term and short-term care plans had been updated where the outcomes were different than expected. The interviewed residents and family members reported they were involved in all aspects of care and reviews/evaluations of the care plans.</p> <p>Dementia - all interRAI assessments were reviewed six-monthly. Six-month care plan reviews align with interRAI assessments. Short term care plans were reviewed and either resolved or added to LTCP. All evaluations were goal focused and were updated as resident conditions changed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) 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>The service facilitates access to other medical and non-medical services. The registered nurses interviewed confirmed that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted (district nurse).</p> <p>Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider.</p> <p>Input from the psychogeriatric team, nurse practitioner, dietitian, physiotherapist and podiatrist were evidenced in resident files as needed.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies in place for waste management. All chemicals are labelled with manufacturer labels and are in original containers. Data information sheets have been updated and were available in all sluice rooms, and the laundry. Chemicals and sluice rooms are locked when not in use. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Gloves, aprons, and goggles are available for staff in all sluice rooms. There is an approved sharps container for the safe disposal of sharps. Interviews with staff described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 28 June 2021. The support services coordinator interviewed described the preventative and reactive maintenance schedules maintained. Any breakages are reported through the electronic system or by leaving a message on the whiteboard. The support services coordinator leads the team of gardeners, maintenance, housekeeping and laundry staff. She works full time and is on call if required for urgent enquiries over the weekend. The weekend supervisor can contact contractors as required for emergencies over the weekend.</p> <p>Hot water temperature checks are maintained at a safe temperature and hot water checks are conducted and recorded monthly by the maintenance person. All equipment including (but not limited to); hoists, weigh scales, and medical equipment has been tagged, tested and calibrated annually. Interviews with staff confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>Residents were observed to safely mobilise throughout the facility. The facility is well maintained inside and out. The outdoor areas have safe paving or decked areas, lawn and gardens. There is easy access to the outdoors for residents in the dual-purpose units which include seating and shade in the garden areas.</p> <p>The dementia unit has large secure gardens/courtyard areas, which are designed to meet the needs of residents who wander. There are quiet, low stimulus areas that provide privacy when required.</p> <p>The electronic doors at the entrances to the facility automatically lock in the evening and open in the morning. The entrances to the facility have been fitted with thermo-scanners to check temperatures of everyone entering the facility as part of the Covid-19 precautions.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing</p>	FA	<p>All resident rooms in the facility have full ensuite facilities. Additionally, there are several communal bathrooms and toilets. Residents interviewed stated their privacy and dignity are maintained while attending</p>

<p>Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>to their personal cares and hygiene.</p> <p>The communal toilets and showers are well signed and identifiable.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are two resident rooms which have been converted into a double room. This room is used for married couples only. Each resident room is spacious enough to meet the assessed resident needs. All beds are of an appropriate height for the residents, hi/low beds are in use for residents at high risk of falls. Residents can manoeuvre mobility aids around the bed and personal space. Resident rooms are personalised to residents' individual taste. Residents interviewed were very happy with their rooms. Staff interviewed reported that rooms have sufficient area to allow cares to take place and staff were seen to use hoists.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large open plan lounge/dining areas with kitchenettes, and smaller seating/quiet areas and dining rooms in each unit. The dining areas are spacious and are easily accessible for the residents. The Kowhai dementia unit has adequate space to allow maximum freedom of movement while promoting safety for those that wander. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility and staff assist them if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	FA	<p>There are dedicated laundry and housekeeping staff. Manufacturers' data safety charts are available. The housekeeping trolley is stored in a locked cupboard when not in use. Cleanliness of the facility was noted to be of a high standard.</p> <p>All linen and towels are laundered off site and collected and dropped off twice a day. Personal clothing is laundered on site. The laundry has a clear dirty to clean flow. Chemical data sheets and personal protective</p>

<p>services appropriate to the setting in which the service is being provided.</p>		<p>equipment were readily accessible in the laundry, sluice rooms and cleaning cupboards. The laundry and housekeeping staff have completed training in chemical safety. Residents and relatives interviewed reported satisfaction with the housekeeping and laundry services especially since a new labelling machine has been purchased.</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>The New Zealand Fire Service has approved the evacuation plan for the original facility and the adjoining Owen Street facility. Fire evacuation practice documentation was sighted for each area September 2020. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Emergency equipment is available. Civil defence boxes are available in each wing (sighted) and are checked regularly.</p> <p>The service has an onsite generator, so essential services can be maintained. There is also emergency battery backup which supplies easily identifiable power points in the facility. The emergency battery and generator ensure all medication fridges, and the kitchen are fully functional. The staff stated that they have spare blankets and alternative cooking methods if required. There is food stored for at least three days. There is more than sufficient water stored in large water tanks to meet the requirements of 20 litres per person for 7 days. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The emergency plan contains detailed information and accompanying map of the facility with clearly located 'shut off' valves for electricity and gas with photos of what to look for and step by step instructions to follow. Staff are trained in starting the generator.</p> <p>First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. All members of the activities' teams have current first aid certificates.</p> <p>There are call bells in all communal areas, toilets, bathrooms and residents' rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week.</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</p>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. The original part of the facility is heated with radiators in the corridors and in residents' rooms. The Owen street part of the facility has under floor heating. Air conditioners are placed around the facility to ensure a comfortable temperature is maintained. Residents and relatives interviewed stated the environment is warm and comfortable.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. A registered nurse is the infection control facilitator and is also an accredited vaccinator. One registered nurse from all five units in the facility and the quality manager form the infection control committee. The annual infection control programme is developed, approved and reviewed annually by the infection control facilitator, the quality manager and the infection control committee. The infection control facilitator provides a monthly report which is discussed at the quality and staff meetings. Staff and residents are encouraged to have the flu vaccine annually. The infection control facilitator vaccinates the staff, and the GP vaccinates the residents.</p> <p>There are thermo-scanners installed at the entrances to the facility, which record the temperatures of everyone entering the building. If someone's temperature is out with parameters, an alarm is activated, and the persons temperature is checked by a registered nurse. All visitors are reminded not to visit if they are feeling unwell. Contact tracing measures remain for all visitors and contractors to the facility. Extra hand sanitiser has been placed around the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control programme is linked to the quality systems and includes the facilities mission and values. There is an annual look back period to set the new programme and pre-empt new risks. The IPC coordinator can access external DHB, infection control nurse specialist, microbiologists, public health team, and GPs specialist advice when required. The facility is a member of 'Bug Control'. The facilitator ensures compliance with the objectives of the infection control policy and works with all staff to facilitate the programme. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. The infection control facilitator was due to attend the infection control conference in 2020, which was cancelled due to Covid-19, she completed online training around infection control. Infection control meetings are held three monthly, and sooner if there is an emergent issue to discuss. The current infection control programme is currently under review. Six of the seven goals have been completed and one goal is ongoing. There is a vaccinations fridge on site. The infection control facilitator maintains temperature data loggings weekly and completes cold chain recordings to maintain accreditation. There are only the required number of vaccines required on site to vaccinate staff.</p> <p>Covid-19</p> <p>A Covid-19 plan was developed and implemented to include all areas of the service. Red and green areas were identified with one area set aside for residents being admitted to the service and completing the isolation period. This area had dedicated staff covering all shifts. The pandemic plan includes staffing, laundry, kitchen, housekeeping, floor services, GP services and visitors. Adequate supplies of personal protective equipment/outbreak kits were sighted on each floor with a central 'emergency' supply. Registered nurse interviewed could describe where to access information around each level of lockdown requirements.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Te Hopai has a suite of infection control policies including antimicrobial usage and outbreak management. The infection control manual reflects current best practice. The infection control programme defines roles and responsibilities of the infection control facilitator. The programme is reviewed annually by the infection control facilitator, the committee and the quality manager.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator attends the infection control conference and completes online training. The facilitator maintains vaccinator accreditation, a current first aid/CPR certificate and administers staff flu vaccines. The facilitator attends infection control updates when available through CCDHB. All new staff receive infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs including hand hygiene, standard precautions, the use of personal protective equipment. Non-clinical staff also receive infection control training relevant to their role. The members of the committee are encouraged to present staff education at meetings. Sessions held have been around outbreak management, and antibiotic usage in palliative care. There is evidence of consumer and visitor education around influenza and encouragement to have the flu vaccines.</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</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control facilitator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Individual electronic infection registers are completed for all infections, which provides a monthly electronic report through the resident management system and the electronic medication systems. Reporting has been increased to include topical antifungal applications. Antimicrobial usage continues to be monitored, to ensure correct utilisation of antibiotics. The infection control facilitator reviews all resident infections, laboratory</p>

programme.		<p>reports and medication charts to ensure appropriate treatment is in place. There is close liaison with the GP, and the nurse practitioner. The GPs interviewed commented on the review and lower usage of antimicrobials in the facility.</p> <p>Short term care plans were in place for all residents with a current infection. These had been reviewed regularly and evidence symptoms, and additional information is added by the registered nurses.</p> <p>Results of infection control data collated is graphed and discussed at staff meetings. Infection control is internally benchmarked which continually compares infection control data gathered.</p> <p>There have been three outbreaks since the previous audit; norovirus in 2019, scabies (not notifiable, but treated as an outbreak) in 2020 and norovirus in 2020. Logs were maintained, notifications to the public health team were timely. Staff were well informed, and the outbreaks were well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Te Hopai has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers and restraints should these be required.</p> <p>The policy includes that enablers are voluntary and the least restrictive option. There were fifteen residents with enablers at the time of the audit (11 with bedsides, 3 with lap belts and 1 using a reclining chair). Either the resident or their EPOA signs consent to ensure it is voluntary. There were no restraints in use at the time of the audit.</p> <p>Strategies are in place to minimise the use of restraint including, sensor mats, hi-low beds, mobility aids, monitored doors and bracelets for wandering residents, one-to-one staffing if required in emergency situations and regular observation of residents.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Data collation around medications identified that residents admitted to the facility had a high usage of antipsychotic medications in 2020 compared to 2019 and 2018. Residents were found to have been prescribed antipsychotics prior to admission which did not meet the Australian Government department of health ‘steps for safe prescribing’. Due to the side effects these medications have, monitoring of antipsychotic medication was commenced through the benchmarking system.</p>	<p>A corrective action was implemented in June 2020, where prescribing and the reasons for administration were investigated. Results were discussed at the quality meeting. A further in-depth survey was conducted in November 2020 to review the appropriateness of prescribing. It was found that regular dose reviews had been carried out and that inappropriate drugs were discontinued as soon as fitting to do so. A full review of residents using antipsychotics, antidepressants, anxiolytic and hypnotic drugs (total 76) was conducted in October 2020. Thirty-nine of these residents were on antipsychotics, including two residents on two types of antipsychotics. Since that review six residents have stopped using antipsychotics, and four residents have had a reduction of dose.</p> <p>Quality data reviewed evidenced a low usage of benzodiazepines, which has remained below the benchmark and polypharmacy rates have remained below benchmark since December 2019. There has been a drop in insomnia from fourteen to 6 from September 2020 to December 2020.</p> <p>The two GPs interviewed were complimentary in the pro-activeness of the team. They reported the very low (almost no) use of antipsychotics in the dementia</p>

			unit, this was evidenced in the dementia medication files reviewed.
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	CI	<p>Following resident surveys, it was identified that residents did not always know if their suggestions were followed up. During a resident meeting the residents felt that new residents could be introduced to the service much better. It was decided that the residents would lead an initiative to welcome new residents to the service.</p>	<p>During August 2020 a resident consultation group was set up to investigate ways to welcome new residents to the service and ensure that they were fully informed. The residents felt that the current information was not as informative as it could have been. With the support from the diversional therapist, the residents have designed a new service information leaflet. The leaflets included information that the residents felt that they needed to know on admission. As well as the leaflet the consultation group developed a video for new residents. The consultation group and the Te Hopai management team plus board have worked together to evaluate and update the leaflets. The video is in its first iteration. The Board member discussed how excited the board are around this process.</p> <p>As a result of this initiative, resident satisfaction was improved. Te Hopai also self-reported how residents reported a renewed sense of energy and purpose. This has also been reflected in the high level of compliments received by the service (compliments seen).</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The diversional therapist reported there was very little usage of the outdoor spaces in the dementia unit. A quality initiative was implemented to improve the outdoor courtyards to make them more appealing, so residents enjoyed the space.</p>	<p>A relative transformed a small area of the courtyard into 'an oasis' for their resident to enjoy. It was noticed many residents started enjoying this space and staying outside longer. A 'wish' book was commenced by the activities team, which contained pictures of plants, furniture and other items the residents and staff would like to see in the outdoor spaces. A plan was drawn by the diversional therapist with input from residents, staff and relatives. During the process a resident passed away, the relatives were keen to see the development of the outdoor area proceed and donated money towards completion. Funding for the project came from donations to purchase trees and plants, pots were donated from relatives and volunteers. The facility has provided furniture and cushions, and a new umbrella for shade. There is a variety of plants including flowers and vegetables which were grown and made into meals.</p> <p>Feedback from relatives have been around the residents using the spaces more frequently, and these spaces have been transformed into another space. During the audit residents were observed enjoying the spaces with relatives and watering the plants. Residents appeared to be enjoying a walk looking and</p>

			<p>talking about the plants with staff. Relatives use the courtyard area often (during nice weather) when visiting their relatives. The diversional therapist reported residents are settled in the garden and she was able to recite poetry while residents were in the garden. One resident was able to recite most of the words of a poem while outside. There are lots of photographs on notice boards of various occasions when residents have enjoyed the outside spaces. There have been three incident reports of challenging behaviour in the Kowhai unit since the project started. Relatives interviewed during the audit were complimentary of the courtyard improvements and commented there are often residents in the space wandering through the area or sitting in the area on nice days.</p>
<p>Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	CI	<p>The quality and training manager and infection prevention and control manager undertake research and attend relevant meetings, conferences and trainings to ensure they are aware of current best practice. The service is able to provide funding for their contracted medical practitioners to expand their knowledge if required.</p>	<p>In early 2016, the infection control team identified that 13% of antibiotics prescriptions did not meet the antibiotics prescribing criteria. The service accessed and provided a copy of the antibiotic prescribing guidelines to all GPs to encourage appropriate prescribing. Training and collegial support was provided to registered nurses to enable them to feel more able to discuss prescribing practices with the GPs. Because of these interventions there has been a 75% increase in the use of nitrofurantoin or trimethoprim as the first line of treatment for urinary tract infections (best practice) and a reduction from 13% to 6% of antibiotic prescriptions that did not meet the guidelines.</p>

End of the report.