

Avatar Management Limited - Maida Vale Retirement Village

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

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| Legal entity: | Avatar Management Limited |
| Premises audited: | Maida Vale Retirement Village |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical |
| Dates of audit: | Start date: 23 February 2021 End date: 25 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: | 87 |

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 |
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|  | 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 |
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| | 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

Maida Vale Retirement Village provides rest home, hospital (geriatric/medical) and residential disability – physical services level care for up to 94 residents. The service is family run and owned by Avatar Management limited. The facility is managed by the owner/manager with assistance from a site services manager, village manager, a clinical services manager and two charge nurses. Residents and families spoke positively about the care provided.

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

This audit has resulted in a continuous improvement rating in relation to food services. Areas requiring improvement related to management of complaints, linking of all aspects of the quality improvement system, corrective action planning, evidence of completion of all education requirements and performance reviews, staffing requirements, storage of chemicals, the call bell system and the need to complete a quality review of restraint and enabler use.

Consumer rights

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

A complaints register is maintained, with the process for addressing complaints being reviewed. Residents knew how to make a complaint with information to do so well displayed and available.

Organisational management

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The scope, goals, direction and values of the organisation are reviewed by the directors of Avatar Holding Ltd. who oversee the management of Maid Vale Retirement Village. The Strategic Plan (2020 – 2025) and The Business Plan (2020 – 2023) define areas for development, with responsibilities and timeframes. The directors meet weekly to discuss progress and any matter arising. The managing director has been in the role for 21 years.

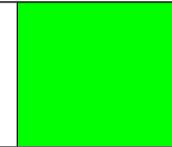
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse/incidents events are documented and investigated with improvements made where possible. Risk, including health and safety risks, are identified and plans developed to mitigate these. Policies and procedures support service delivery and were current.

The appointment, orientation and management of staff is based on current good practice. A training development plan is available with a range of training opportunities offered to staff. An electronic system to review staff performance has been developed. Staffing levels and skill mix are defined and were being reviewed at the time of audit.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

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

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

Safe and appropriate environment

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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| <p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p> | | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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The organisation has implemented policies and procedures that support the minimisation of restraint. Six residents were using enablers and one resident was using a restraint 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

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| <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, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. Management of infection prevention and control is appropriate for the size and scope of the facility.

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) |
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| Standards | 0 | 43 | 0 | 5 | 2 | 0 | 0 |
| Criteria | 1 | 92 | 0 | 2 | 6 | 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Maida Vale Retirement Village has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, last held 19 February 2021.</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>Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. This includes delivery of treatment, photos, and transportation for outings. A separate consent was obtained for flu vaccination. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care. One of the younger residents confirmed their advance care plan reflects their current wishes and they are pleased these are regularly reviewed.</p> |

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| <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 and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Two of the village residents are available to act as an advocate if required.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their 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> | PA Low | <p>The comments/compliments/complaints policy, process and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The 'It's OK To Complain' form is well displayed/accessible for resident/family members to make a complaint with locked boxes around the facility for these to be placed. Complaints can also be made verbally to any member of staff. The owner/facility manager reported an 'open door' approach and this was supported by two village advocates who are available to act for residents in the rest home and hospital facilities.</p> <p>The complaints register reviewed and discussed with the clinical services manager (CSM) did not provide a full record of the management of the complaints reviewed with the ability to track the course of the complaint difficult. The eight complaints reviewed did not demonstrate a timely review of the complaint and that the complainant had been formally notified of the findings, any actions to be taken and their right to access advocacy services should they wish to do so. Where an action plan had been developed, the tracking of the completion of all actions was not always clearly evident (Refer criterion 1.2.3.8). The owner/facility manager is responsible for the overall complaint management process and follow up. The CSM takes responsibility for all complaints with a clinical component.</p> <p>Staff interviewed confirmed an understanding of the complaint process and how to support a resident wanting to make a complaint.</p> <p>There have been three complaints received from the DHB in the past year. No complaints have been received via the Health and Disability Commissioner (HDC).</p> |

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| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>Residents 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, from discussion with staff and there are two advocates living in the village who will meet with residents. The Code is displayed in the entrance areas together with information on advocacy services and how to make a complaint and feedback forms. Copies of the brochures and complaint forms are also available in each resident's room.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, staff were observed closing curtains and doors when providing cares.</p> <p>Residents are encouraged to maintain their independence by maintaining contact with friends and organisations they belonged to prior to admission to the rest home, and arranging their own visits to the doctor if they were able. Care plans 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 during admission and incorporated into their care plan.</p> <p>Care staff interviewed could explain what actions they would take if they saw any signs or had concerns of abuse or discrimination. Residents interviewed shared that they felt safe at Maida Vale and had not seen or heard of any examples of such behaviours.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Staff support the three residents in the service 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. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents interviewed reported that staff acknowledge and respect their individual cultural needs. A cultural education session was held on 22 January 2021.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> | <p>FA</p> | <p>Residents verified they were consulted on their individual, ethnic, cultural, spiritual values, and beliefs on admission, and on an ongoing basis. All care plans reviewed reflected the personal preferences and individual requirements of the residents, with goals and interventions documented to ensure these were</p> |

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| <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | | <p>met. Monthly church services are held for different denominations. One resident who requires full assistance informed that staff ensure they are ready when they ask to attend church in the local community.</p> |
| <p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Residents and families interviewed stated that they felt safe and were free from any type of discrimination or exploitation. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. The registered nurse confirmed they have completed professional boundaries through the Nursing Council of New Zealand.</p> |
| <p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Maida Vale Retirement Village has a professional network with a range of external specialist services and allied health professionals. These include wound care specialists, mental health services for the elderly, physiotherapists and dieticians. These are a source of additional knowledge and expertise to supplement their own skilled staff.</p> <p>The RN reported that they have access to online training and are made aware of external opportunities for syringe driver training but ongoing training is not adequately documented.</p> <p>Actions are taken to ensure the needs of the younger people are met as far as possible with staff expressing an awareness of their different needs and residents and a family member reporting the flexibility of daily routines to accommodate family and friends visiting and when they want to go out.</p> <p>The general practitioner interviewed confirmed that the service sought prompt and appropriate medical intervention and were responsive to medical requests.</p> |
| <p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Each resident's file reviewed contained written documentation of family contacts, and confirmation of contact in the progress notes. Adverse event forms demonstrated open disclosure and effective communication with residents and their family. Family members stated that they were informed in a timely manner of any changes in their relative's health status.</p> <p>Interpreter services are available through the District Health Board. Although the service has not been used, contact details were available. The RN also gave examples of using a white board and word cards for hard of hearing residents.</p> |

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| <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>The strategic plan (1 April 2020 – 31 March 2025) and the business plan (1 April 2020 – 31 March 2023) and other organisation-wide documentation, which is reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term actions and the timeframes for completion. The staff are involved in the development of the yearly review of the plan through developing a 'wish list' of priorities (sighted). The leadership team discuss aspects of these plans at their regular forums, as confirmed in meeting minutes reviewed. This included food services, facilities, staffing, training, health and safety, occupancy and planned admissions, and current issues/risks.</p> <p>The service is managed by a managing director (owner/facility manager) who has been in the role for 21 years. Responsibilities and accountabilities are defined in a job description. The owner/FM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through several aged care associations/groups and expert advice/input (e.g., accountant, lawyer, clinical consultant, education consultant, IT consultant)</p> <p>The service holds contracts with Taranaki DHB for aged related residential care (hospital and rest home care). Long Term Support-Chronic Health Conditions) and a non-aged care agreement with the MoH) for younger people with a disability (YPD). The facility is licensed for 94 beds; however, the normal occupancy is 90, with the extra four beds used in case of couples. At the time of audit, there were 87 residents; 51 rest home and 36 hospital level care. Six of these residents were receiving services under the YPD contract.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p> | <p>When the owner/FM is absent, the village manager acts in this role under delegated authority. During absences of key clinical staff (the CSM and two charge nurses), the clinical management is overseen by one of the clinical management team who take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. The owner/FM reported that the clinical consultant is also available for support and advice.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p> | <p>PA Low</p> | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes through an external company programme and clinical incidents including infections, falls, skin tears and pressure injuries. Several projects to improve facilities, manual handling practices, supplies and the food service, especially for those residents with dementia</p> |

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| <p>maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>have been progressed (Refer 1.3.13.2).</p> <p>Bi-monthly meeting minutes of the quality and risk committee reviewed confirmed a set agenda that covers a range of quality related activities and data including health and safety, incidents and complaints, audit outcomes. However, minutes reviewed did not show that all relevant areas were covered. The audit programme is not yet well established with good analysis of results data. There is no restraint committee/forum to overview restraint and enabler use, despite 'restraint' being one of the fixed agenda items (Refer also criterion RMSP 2.2.5.1). Discussions around risk, and in particular clinical risk, were not evident.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities and updates at regular staff meetings. For areas requiring improvement following straight forward incidents, complaints and audit activity, relevant corrective actions have been developed and implemented. However, a sample of incidents and complaints reviewed showed that not all were being reviewed in sufficient detail to address all issues raised. Follow-through of action plans was not always timely (Refer also criterion 1.1.13.3) nor was it evident that the actions had been effective in addressing the areas for improvement. Resident and family satisfaction surveys are completed annually. The most recent survey showed a good response rate. The report had only recently been received and was yet to be reviewed and discussed by the quality and risk committee. Review of the data showed that overall residents were very happy with the service.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Documents are available both electronically and in paper version, with folders updated as necessary.</p> <p>The owner/FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register included risks related to human resources, maintenance, financial, occupational health & safety, national disaster emergency/pandemic, marketing/reputation and clinical safety. The FM was familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed; however, the development of actions plans did not always address all identified areas, and those of a more serious nature, were not always implemented in a timely manner (Refer 1.2.3.8). Adverse event data is collated through the external benchmarking programme with basic analysis and trending and graphed information is reported to the quality and risk committee.</p> |

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| <p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>The owner/FM described essential notification reporting requirements. They advised there have been notifications of significant events made to the Ministry of Health in relation to RN shortages (two), changes to the CSM role and a resident fall with a fracture. A notification to the Nursing Council of New Zealand was also made in December 2019.</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>PA Low</p> | <p>Human resources 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 were being consistently implemented and records maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. There have been some developments in the programme over the past year. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation. A performance review is to be completed after an 80-day period and then annually. Not all staff have completed these as required.</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.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed showed that not all staff have completed mandatory training requirements.</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 Moderate</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes. At the time of audit an external consultant has been working with the owner/FM to review staffing requirements based on resident acuity. Data was reviewed and discussed with the Woodrow Grove Hospital charge nurse (the first area to complete acuity calculations). Staffing for Mountain View Rest Home has yet to be reviewed using this process. The owner/FM completes the roster in the first instance which is then adjusted as required and confirmed by the CSM.</p> <p>Care staff and clinical leaders reported that cover for unplanned leave was problematic, with not all shifts able to be covered from the current casual pool. This was supported in review of the last two weeks of rosters. Even with shifts fully covered, staff in Mountain View Home reported being very busy and feeling unable to complete all work required. Relatives interviewed also reported that staff were 'rushed' with their work. Mountain View Home is a spread out complex on two levels. There are 12 ORA care suites/apartments in Mountain View Home (MV). These are included in the roster. During the night at MV</p> |

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| | | <p>there is one RN and two HCAs on duty from 12 midnight (MN) to 8am and 7am respectively. There is a two-hour period from 10pm to 12MN where there is one RN and only one HCA. The risks around this have become apparent following an event during this period where a resident had to be transferred to hospital and there was insufficient staff to meet the needs of the other residents in the building. The FM has added HCA cover for this period on the next roster. However, at the time of audit, this is an area of risk.</p> <p>The 14 Ocean View Apartments (OVA) are overseen by the charge nurse of Woodrow Grove Hospital (WG). There are three rest home residents in these apartments under ORAs. This area is staffed by HCAs working 12-hour shifts.</p> <p>Staff also reported that they cover calls to the village during the night, and although this is reported to be rare, this poses a risk to both the staff member attending the call and creates a gap in staffing while the person is attending the call.</p> <p>An afterhours on call roster is in place, with those on call reporting that this does not always work well for them, with frequent calls to the CSM and charge nurses to do with staffing cover.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage in both main clinical areas.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>All components of the residents' records reviewed included the residents' unique identifier. Files were well organised and fully integrated, including information such as wound care plans, allied health visits, laboratory results, and medical files. All records are kept in the nurses' stations in lockable cupboards, where the doors are required to be shut if no staff are present. Archived material was available and stored securely in locked cupboard for current residents, while discharged notes were transferred to a secure container and stored for the required time before disposal.</p> <p>Detailed progress notes were maintained and updated each shift. Staff signatures and designations were sighted.</p> <p>Staff were aware of the need to ensure personal and private resident information is not on public display.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful</p> | FA | <p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the general practitioner (GP) for residents accessing respite care, including a check list to ensure medicines</p> |

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| <p>manner, when their need for services has been identified.</p> | | <p>have a prescription.</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. Service charges comply with contractual requirements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a check list as to what paperwork to send and who to contact to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information is provided for the ongoing management of the resident in writing and via telephone. All referrals are documented in the progress notes.</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>Medications are supplied in blister packs from a contracted pharmacy. These are reconciled against the medication chart by the RN on duty when they arrive. They are then entered into the electronic system as a record of delivery.</p> <p>Each of the 18 medication charts reviewed contained a current photograph and their allergy status was recorded. All medications were appropriately charted. Discontinued medications were signed by the general practitioner and pro re nata medications had indications for use.</p> <p>Two medication rounds observed were performed in a safe manner. The RNs wore an apron indicating they were unavailable. Staff had a clear understanding of their responsibility around adverse reactions, and where to obtain information on the medications. Medication trolleys are available for each wing throughout the facility with individual folders for each resident's medicines including a medication alert page for new or changes to medication.</p> <p>All medications are stored in a locked cupboard in a methodical way and evidence of stock rotation was observed. Controlled drugs were locked in a metal cupboard and administered by two staff. The controlled drug register had accurate balances and evidence of weekly and six-monthly stock balances. Temperature of the medication fridge are recorded on a daily basis and were within the recommended range and all eye drops are dated and within the use by period.</p> <p>At the time of audit, no residents were self-administering their medications. Policies and procedures were available and the CN was able to explain the process if required.</p> <p>There is a specimen signature sheet in each medication trolley indication medication competent staff.</p> |

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| | | Standing orders are not used. |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food service is provided on site by two qualified chefs, a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (20 March 2020). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Avatar Management and is current until 8 November 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Food stored in the fridge was covered and dated with meat stored below other food. Dry goods in the pantry were stored appropriately with dated containers and evidence of stock rotation seen. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. Food is cooked in the kitchen and transferred using hot boxes to Woodrow Grove building to pre heated bain-maries. Temperatures are taken at point of service.</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 diets are catered for and special crockery and cutlery were available. The meal time observed was calm, unhurried and residents stated they enjoy the variety of meals. Those requiring assistance were given it in a respectful and dignified manner. Use of a percutaneous endoscopic gastrostomy (PEG) feeding tube is being well managed with oversight from a dietitian and specifically trained staff.</p> <p>A quality initiative has been implemented in relation to residents experiencing weight loss that is worthy of a continuous improvement recognition.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |

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| <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>Information is documented using validated nursing assessment tools, such as, mobility assessment, falls risk, skin integrity and a nutritional profile, as a means to identify any deficits and to inform care planning. Further assessments were made if a need was indicated. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of five trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process. Staff informed interRAI is used for residents on the YPD contract, which was confirmed in both of the YPD residents' files reviewed.</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>The 11 care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. All care plans reviewed were documented within a template that includes goals and action plans for residents' needs holistically covering physical, mental, social and spiritual needs.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation with monitoring charts observed for weekly weight management, behaviour charts and repositioning of frail residents. A range of equipment and resources was available, suited to the level/s of care provided and in accordance with the residents' needs. Ceiling hoists are available in the majority of rooms and continue to be added as rooms become vacant.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p> | <p>FA</p> | <p>The activities programme is provided by two trained diversional therapists (DT) holding the national Certificate in Diversional Therapy, and an activities coordinator. The team leader has only been in the role for three weeks and plans to develop the programme further with gender specific groups, more activities and more detailed documentation.</p> |

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| <p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated and as part of the formal six monthly care plan review and in response to feedback after activities.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings. There are three vehicles available for outings one specific to wheelchairs, an eight seater van and a large 22 seater vehicle. One of the DTs holds an appropriate licence for driving this. Residents interviewed confirmed they find the programme interesting if somewhat lacking in variety which is now being addressed by the new team leader. Efforts are being made to ensure activities meet the needs of the younger residents including providing some events specifically for them; although two of these residents suggested they would appreciate more.</p> |
| <p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Residents' care plans are reviewed six monthly in line with interRAI reassessments or as a resident's needs change. Where progress is different from expected outcomes adjustments are made to the interventions, signed and dated. Residents are evaluated every shift with staff reporting to the RN any changes from the usual patterns of behaviour. Progress notes are written for each resident on all shifts.</p> <p>A six monthly care assessment form is completed with input from all providers of healthcare and discussed with the resident and family.</p> <p>The charge nurse (CN) reported that short-term care plans are used for such things as infections or wounds and were assessed weekly or sooner if medically required. When necessary they are transferred to the long-term care plan if not resolved within six weeks. Residents and family spoke of being involved in the evaluation process.</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> | <p>FA</p> | <p>If the need for other services is identified, the GP will complete a referral to seek specialist provider assistance. During the interview with the CN examples were discussed and forms reviewed for such services as the dietician and wound specialist nurse. Family are kept informed during the process as was verified by the family contact page. Residents are free to choose the house doctor or maintain care under their own GP. The involvement of allied health professionals in the files of YPD funded residents is well documented and one person is supported to access additional support at their request.</p> <p>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> |

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| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>The maintenance team has recently reviewed the management of waste and hazardous substances as part of an environmental audit across all of its services and are currently putting proposed changes in place. Meantime staff continue to follow the documented processes for the management of various types of waste and infectious and hazardous substances. A contractor assists with this process. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and provides access to relevant on-line training for staff. Material safety data sheets were available where chemicals are stored. During interview, the head housekeeper described actions to take should any chemical spill/event occur. (Refer finding in 1.4.6 regarding the storage of household chemicals.)</p> <p>There is provision and availability of a range of protective clothing and equipment. Staff were observed using this appropriately. Hand sanitiser is readily accessible throughout each building.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>Current building warrants of fitness were on public display. The expiry date for the Ocean View Apartment building warrant of fitness is 6 July 2021 and those for both the Mountain View and Woodrow Grove buildings are 18 November 2021.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. An internal/external environmental checklist has been developed and is used to guide monthly tasks the maintenance team need to follow up. In addition to observations of the environment, three members of the maintenance team were interviewed and documented records of monitoring systems were provided. These included for the testing and tagging of electrical equipment, safe hot water temperature checks and the calibration of bio medical equipment. Actions are taken to remedy any deviation from the expected norm.</p> <p>External areas are landscaped, patio areas and pathways are safely maintained and were appropriate to the resident group/s and setting. A pool area is safely fenced and ramps between the different levels of Mountainview have non-slip surfaces.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. A maintenance folder is used to record any required tasks or repairs and entries are signed off once completed. Residents and family members expressed satisfaction with the environment.</p> |

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| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. In the upper wing of the Mountainview building three residents share one bathroom of a shower and toilet, and in another area two residents share one bathroom. Downstairs there is one area where six residents share two bathrooms. All other rooms have an ensuite. All rooms have a hand basin. There are three other communal toilets for residents' use. In the Woodrow Grove building Camelia wing, 12 bedrooms have toilets attached and these residents share two showers. A third bathroom is shared by two residents. Cherrylane wing has shared ensuites for the 20 rooms, except for the two other rooms at the end which have access to a communal bathroom. Approved handrails are secured beside the toilet and in shower areas. Other equipment/accessories are available to promote residents' independence including shower trollies.</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>Adequate personal space is provided that allows residents and staff to move around within their bedrooms safely. The majority of bedrooms provide single accommodation. Spacious open areas at the end of two different wings of the Woodrow Grove building do not have doors; however, the bedroom areas are around a corner, curtains have been installed around the beds and there are dividers between the two separate beds. The occupants of all shared personal spaces have agreed to this set-up, which have been previously approved. Rooms are personalised with furnishings, pictures, photos and other personal items displayed.</p> <p>There is room to store mobility aids and wheelchairs for example in each resident's room. Hoists were in storage rooms and mobility scooters were in wider corridor areas and lounge areas of the apartment building. Staff and residents reported the adequacy of bedrooms and confirmed that most were on the larger side.</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>Large communal areas are available for residents to engage in activities. The dining and lounge areas in all three buildings are very spacious and enable easy access for residents and staff. The Mountainview building has a full width dividing door between a Chapel/activity room and the dining room and this may be left open or closed according to preferences. With a range of smaller seating areas in all buildings, residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> |
| <p>Standard 1.4.6: Cleaning And</p> | PA Low | <p>Documented laundry instructions are available, as are those for managing laundry products. A dedicated on- site laundry is used for all bed linen, bathroom linen and personal clothing. One laundry staff person</p> |

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| <p>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>demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen and another new person described the orientation process, which is still underway. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Household staff undertake cleaning duties according to detailed schedules and appropriate on-line training is provided through company that provides cleaning products. Chemicals were in appropriately labelled containers; however, they were not always being stored in a secure area and this factor has been raised for corrective action. A head of household had just been appointed and this person described their commitment to follow up on any cleaning duties not completed at the level expected.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme via six monthly environmental and infection control audits and an external one by an infection control expert. Weekly meetings with the head of household have commenced and feedback is provided to housekeeping staff. One of the managers does a daily visual inspection and feeds back to the management team and the head of housekeeping as required.</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>PA Moderate</p> | <p>Policies and procedures, a civil defence planning folder and one on emergency management are available. Staff interviewed were familiar with their content, described procedures to follow and confirmed they receive education on these topics when they start working at Maida Vale and every year thereafter. This was confirmed in staff training records.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 18 April 2002. Trial evacuations are undertaken according to New Zealand Fire Service instructions, which were sighted. The manager responsible for coordinating fire and emergency training provided documentation confirming the most recent were 28 July 2020 and Woodrow Grove on 29 September 2020. New staff orientation includes fire and security training, which has recently been provided with assistance from the organisation's fire compliance company. 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 and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region. Contents of civil defence storage bins are being checked six-monthly Last check February 2021). Two water storage tanks are located around the complex with a third awaiting installation. The facility has access to a generator that has a suitable connection plug into Mountainview. Emergency lighting has recently been upgraded and is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance; however, these are not operating in a safe manner and a corrective action has been raised. Staff carry a walkie talkie to aid communication around these large premises.</p> <p>Security arrangements are in place. External lighting has been strategically positioned, doors are locked</p> |

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| | | at a predetermined time, most windows have security latches in place, security cameras with appropriate signage are in place and a security company undertakes walk-through checks around the premises at night. |
| <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 some have doors that open onto outside garden or small patio areas. Residents' rooms and communal areas in Mountainview are heated via gas fired wall mounted radiators, while Woodrow Grove has a gas fired air circulation system that provides warmth through ceiling mounted vents. The Ocean View Apartment building has a similar ceiling mounted vent system, plus some heat pumps. All areas are thermostatically controlled and were well ventilated during the warmer weather throughout the audit. Residents interviewed confirmed the facilities are maintained at a comfortable temperature and additional heating was provided for one couple who expressed concern. There is an external designated smoking area for residents who smoke.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the district health board clinical nurse specialist. The infection control programme and manual are reviewed annually.</p> <p>The CN from Woodrow Grove unit is the designated IPC coordinator assisted by a team including staff from household and kitchen services, CN from Mountain View unit and Clinical nurse manager. Infection control matters, including surveillance results, are reported monthly at the quality/risk committee meeting. Input from the infection control coordinator for the DHB is utilised as required.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. A QR code is available at all entrances for scanning. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p> | FA | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for eighteen months. The IPC coordinator undertakes annual online training to remain current with relevant updates. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit and Covid-19 web site, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and</p> |

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| infection control programme and meet the needs of the organisation. | | <p>resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2021 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. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews and observation verified staff have received education on infection prevention and control at orientation. Education is provided by suitably qualified RNs and the IPC coordinator as well as online training using Care Online programme. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is under review as documentation of training was a finding (see 1.2.7.5). Tool box talks were used to keep staff informed of information relative to Covid-19.</p> <p>There have been no outbreaks since the last audit.</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</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies/ Herpes. The IPC coordinator reviews all reported infections and these are documented. New infections</p> |

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| <p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | | <p>and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Information is documented on an infection control monitoring form detailing which part of facility, new or repeat infections, type of infection, treatment provided and effectiveness. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical nurse manager, IPC committee and facility manager.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>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 restraint coordinator (the hospital charge nurse) 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 day of audit, one resident was using a restraint and six residents were using enablers, 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 on review of the file of the one resident using a restraint and from interview with the restraint coordinator.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | <p>FA</p> | <p>The restraint coordinator is responsible for the approval of the use of restraints, along with the GP and occupational therapist. It was evident from review of the file of the one person using a lap-belt restraint and interview with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraint is minimised and is being monitored.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on the resident's file. 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</p> | <p>FA</p> | <p>Assessments for the use of the one restraint were documented and included all requirements of the Standard. The restraint coordinator undertook the initial assessment with input from the resident's</p> |

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| <p>assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | | <p>family/whānau/EPOA and an occupational therapist. The restraint coordinator described the documented process. Families confirmed their involvement in all aspects of care and reported they spend time with resident daily and when they are using their restraint/lap-belt. The general practitioner is involved in 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. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the record of the resident who was using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p> | <p>FA</p> | <p>The use of restraints is actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members (e.g., the use of sensor mats and low beds).</p> <p>When the one restraint is in use, frequent (two hourly) monitoring was occurring to ensure the resident remained safe. A relative of the resident is normally with the resident during the daily use of restraint period, when the resident is in a wheelchair. Records of monitoring had the necessary details. All processes ensure dignity and privacy are maintained and respected. Photos of correct positioning and management of the restraint are on the file to support staff with comfortable management of the resident.</p> <p>A restraint register is maintained and updated as necessary. The register was reviewed and contained all residents currently using a restraint or an enabler and sufficient information to provide an auditable record.</p> <p>Staff have not received all required training in the organisation's restraint policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This has been organised by the restraint coordinator to be completed during the last two weeks of March 2021 (Refer 1.2.7.5). Staff 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 Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>Review of the file of the resident using a restraint showed that the use of restraint was reviewed and evaluated during care plan and interRAI reviews. There is no restraint committee/group overseeing restraint and enabler use (Refer criterion 2.2.5.1). It was evident from review of the file and interview with the family member and restraint coordinator that the family was very involved in the management and care of the resident.</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> |

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| <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> | <p>PA Low</p> | <p>There was no restraint committee/group; therefore, comprehensive reviews of restraint use that cover (a) to (h) of the standard are not occurring as required. (Refer also criterion 1.2.3.5). The restraint coordinator currently oversees all restraints and enabler use.</p> |
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Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | <p>PA</p> <p>Moderate</p> | <p>A large number of compliments were sighted in the complaints/compliments register and residents and family members spoken with during the three-day audit were complimentary about services provided.</p> <p>Review of eight complaints and discussion with the CSM showed that there was a delay in the process between when the complainant had made the complaint and the receipt of the complaint by the person delegated to investigate the complaint. The forms reviewed showed that this varied between seven days and nearly two months. In one example, an initial response email to the complainant was made within seven days.</p> <p>Establishment of the formal close out of a complaint, including date of the closure, was not easy to establish. The information in the complaints register did not demonstrate a clear pathway of the complaint</p> | <p>Complaints are not being received by the person delegated to receive the complaint in a timely way, nor being addressed within the timeframes required by the Code of Rights.</p> <p>All relevant information related to the complaint investigation and corrective action plan and follow-through of actions was not available to track the progress and outcome.</p> <p>Formal closure of the</p> | <p>The complaints register provides a clear record of the date the complaint was received, the date the complaint manager receives the complaint, all relevant dates throughout the investigation process and the formal closure of the complaint.</p> <p>All relevant</p> |

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| | | <p>investigation and resolution process, including a documented corrective action plan, where necessary, nor evidence of completion of the actions. (Refer also criterion 1.2.3.8). Despite this, there were examples discussed of where improvements had been made as a result of complaints (e.g., the establishment of quarterly family meetings - the first of which was held during the audit period).</p> <p>The DHB portfolio manager was interviewed via telephone and progress in addressing the three DHB complaints was discussed. The portfolio manager had been involved with two of the complaints, in particular, and related family meetings. One of the three complaints has yet to be signed off/closed out by the DHB in relation to follow-through of the required corrective action plan.</p> | <p>complaint with documented notification to the complainant, including their right to access the HDC was not evident.</p> | <p>information, including correspondence, corrective action plans and completion of actions are maintained in a format that can be easily tracked.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.</p> | <p>PA Moderate</p> | <p>The quality and risk committee acts as the key group to link all components of the quality system together. However, minutes reviewed did not show that all relevant areas were covered, according to the fixed agenda. Minutes were lacking in detail and areas that needed further action. The presentation of key indicators and information from clinical areas was inconsistent and the trending of data (with the exception of that included in the external quality/benchmarking programme) was not well developed. One of the charge nurses did provide an example of use of the benchmarking tool/data to identify a link between urinary infections and falls and progressed actions which resulted in a reduction in both infections and falls.</p> <p>Although incident and accident data from the benchmarking tool was sighted there was little evidence of analysis and development of actions to address any areas that could be improved. Results of</p> | <p>Although the quality and risk committee have a fixed agenda covering most relevant areas of quality and risk, it was not evident that all areas are being included for discussion at the bi-monthly meetings. There was an inconsistent approach to information reported to this group in the way of clinical and other indicators. The audit programme is not yet well established with good analysis of results data. There is no restraint committee/forum to overview restraint and</p> | <p>Key components of service delivery are linked to the quality management system through the quality and risk committee, as described in the meeting minutes template.</p> <p>90 days</p> |

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| | | <p>audit activity are not yet well analysed and integrated into the quality system. Plans are progressing to implement audits that were delayed due to the Covid-19 disruptions.</p> <p>Although use of restraint is rare, with one resident currently using a restraint. There is no restraint committee/evaluation of restraint and enabler use across the organisation.</p> <p>Due, in part, to Covid-19 disruptions and several changes in clinical service managers over the past 18 months, there has been some disruption in linking all the necessary components of the quality management system.</p> | <p>enabler use. Discussions around risk and in particular clinical risk is not evident</p> | |
| <p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p> | <p>PA Moderate</p> | <p>A range of corrective action plans were reviewed including for incidents, complaints, audit and following analysis of external benchmarking data. There were examples of improvements resulting from actions (e.g., the reduction in falls and infection in the Woodrow Grove Hospital). This was discussed with the charge nurse in the area. Review of more complex incidents and complaints showed that not all aspects of the incident/complaint were being fully explored to ensure that all areas for improvement were identified. In one example reviewed, actions were noted to manage the immediate event and transfer of the resident to hospital, but a full exploration of what may have been the cause of the event, in order to prevent any similar event, was not evident. With the exception of the Woodrow Grove Hospital example noted above, aggregated data and trends and not being reviewed and analysed to identify opportunities for improvement. Actions plans for more complex complaints were not always being completed in a timely manner and reviewed to ensure that actions had addressed the</p> | <p>While corrective actions are being completed following straight forward events/incidents and low-level complaints, not all corrective actions are reflecting all the issues raised within a complaint or an incident and there is limited and inconsistent evidence to indicate that all actions are defined, followed-through and formally closed off as having been completed.</p> | <p>Corrective action plans address all areas needing improvement, are completed within timeframes agreed and are reviewed to ensure that areas for improvement have been addressed.</p> <p>90 days</p> |

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| | | issues identified. (Refer also 1.1.13.3) | | |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | <p>PA Moderate</p> | <p>Continuing education is planned annually (schedule for 2021 sighted), including mandatory training requirements. This includes both onsite and 'online' programmes and includes cultural values and responsiveness seminars, safe manual handling, continence products, advance directive, advocacy, complaints management, challenging behaviour, for example. The facility is well supported by the training school on site with close connections to those involved, and in particular the training coordinator, competence assessment programme (CAP) tutor, workplace assessor and an education consultant. Staff felt well supported with training opportunities. Mandatory requirements include fire training, infection control, restraint minimisation and safe manual handling. An electronic data base is used to document attendance at training and to identify those with training due and overdue. This is managed by the owner/FM with support from an IT consultant. Data reviewed and discussed with the FM showed that not all requirements have been met (e.g., 23 of the 84 people who should have completed infection control training in 2020 have done so. The restraint coordinator reported that not all staff are current with restraint minimisation and safe practice training. This was planned to occur towards the end of March 2021 (Refer RMSP criterion 2.2.3).</p> <p>An electronic process has been developed to complete performance appraisals. This links to the person's job description competencies. The process involves a self-review and review by several peers. The owner/FM oversees this process and maintains the data base of who has completed these. Reminders are sent to staff to complete these via the email system. Data reviewed showed that a large proportion of staff have not</p> | <p>Data reviewed and interviews with staff indicated that not all required mandatory training is being completed as and when required. Documenting of all training completed in a consistent and complete way was not evident. Records showed, for example, that of the 84 people who should have completed infection prevention and control training in 2020, 23 had done so.</p> <p>There is an electronic process to complete performance appraisals. Records indicated that 29 staff out of the 49 staff due appraisals have not yet completed these.</p> | <p>All mandatory training occurs as required and there is an accurate record of all training completed. Performance appraisals are completed for all staff as and when due.</p> <p>90 days</p> |

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| | | completed these when due. | | |
| <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> | <p>PA Moderate</p> | <p>There is a comprehensive roster developed by the FM to cover all areas. This is made up of RNs, ENs and HCAs. The roster covers all three areas on the site that accommodate rest home and hospital residents (that is Mountain View Rest Home and Apartments, Woodrow Grove Hospital and the Ocean View Apartments). Mountain View Rest Home and apartments can accommodate up to 47 residents, with 41 of these rooms being dual purpose and six rest home only. Woodrow Grove Hospital can accommodate 35 residents with all rooms being dual purpose. The Ocean View Apartments can accommodate 12 rest home care residents. Woodrow Grove Hospital (WG) is on one level, while the Mountain View Home (MV) is spread over a wide footprint and is on two levels. The Ocean View Apartments (OVA) are on one level.</p> <p>WG and MV have at least one RN on each shift. Other shifts in both areas have HCAs working morning and afternoon shifts with a range of staggered start and finish times. In both MV and WG there are seven HCAs on the morning shift and four HCAs in the afternoon. There are two HCAs at night (from 12MN) in MV and one HCA in WG. The skill/experience level of the HCAs is noted on the roster, with skill mix considered as part of the rostering process.</p> <p>During the audit, residents and staff expressed concerns about the numbers of staff available to do the work required. They reported that staff are rushed to complete the minimum care requirements and that this can cause delays in answering bells and the ability to provide basic care, such as, teeth cleaning and showering. They expressed feeling pressured and 'stressed'. At the time of audit there were several staff</p> | <p>A number of residents and staff expressed concern in relation to insufficient staff and the ability to provide adequate and timely care to residents. The work to review rosters, acuity and workload is acknowledged. At the time of audit there were several staff away on planned and unplanned leave and the ability to fill shifts with 'casual' staff was not always possible. At Mountain View the layout of the facility is a challenge for staff and this is particularly evident during the night. There is to be an increase in staffing over a 10pm-12MN period; however, at the time of audit, this is a gap in service delivery. Those senior staff on call expressed concerns around on-call arrangements.</p> | <p>Staffing is reviewed in consultation with the clinical leadership team to ensure there is adequate cover on all shifts across the facility, considering the facility layout and resident acuity.</p> <p>90 days</p> |

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| | | <p>off on sick leave and ACC leave which was also causing pressure on staffing, with not all shifts able to be filled. Review of rosters showed that five morning shifts were not covered in the past two weeks in MV and that in WG, five shifts in the afternoon were not able to be covered. There are few staff available for casual use. On occasions, RNs work on the floor, delaying their RN duties. It was reported that during weekends there was increased unplanned leave that is not able to be covered. Data was not sighted to support this.</p> <p>In MV there is a two-hour period during the afternoon shift (10pm until 12MN) when there is only one HCA and one RN on duty. Should an incident arise, there is not enough staff to cover the other residents in the spread-out facility. The FM is aware of this situation and has increased staffing during this period on the next roster. Staff on night duty are also heavily involved with laundry duties and some cleaning duties. Staff reported that, on occasions, they are requested to attend calls during the night in the village (where there are 58 independent villas). Although this was reported to be rare, when this does occur, this leaves the other clinical area short of staff.</p> <p>Diversional therapists (three) are on duty five days a week to support activities and have been involved in supporting staff with feeding residents during lunch times.</p> <p>The FM is currently working with an external consultant to review staffing across the service, based on acuity. Calculations have been completed for WG to date.</p> | | |
| <p>Criterion 1.4.6.3 Service providers have access to</p> | <p>PA Low</p> | <p>In addition to two items of cleaning fluids being stored on a shelf off a hallway in Mountainview, cleaning and</p> | <p>Sluice rooms and cleaning and laundry equipment</p> | <p>Ensure designated</p> |

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| designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | | chemical storage areas in all three buildings were found in unlocked storage areas on more than one occasion throughout the audit. Laundry doors did not have locks installed and were left open even when staff were not present. Sluice rooms were also found unlocked. | and chemical storage areas are not always being secured for residents' safety. | areas for the storage of cleaning/laundry equipment and chemicals and for management of hazardous waste are secure at all times. 180 days |
| Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required. | PA Moderate | A 'call system' is installed throughout the different buildings of this service. A light is illuminated above the door of the room/area where the alarm was raised, as well as on master boards. In addition to staff carrying walkie talkie telephones for communication between staff they carry a beeper unit that responds to alarms raised in the respective area. Managers and staff reported that due to the age of the system and the number of interferences from a range of other electronic equipment, the system is no longer reliable, in particular in the Mountainview building. Residents and family members have complained that an alert does not always register when the call bell is pressed. The owners have responded accordingly and sought information and quotes from relevant companies. At the time of audit, the best option was still under consideration. | Managers, staff, residents and family members informed the call bell system is not always reliable when residents push a button for assistance. | Ensure the residents' call bell system is reliable and enables residents to summon assistance when required. 90 days |
| Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: | PA Low | There is no restraint committee/group to evaluate and monitor restraint and enabler use across the organisation and review other aspects required in the standard (e.g., policy and education). The restraint coordinator currently oversees the one restraint in use | There is not currently a restraint minimisation committee; therefore, comprehensive reviews of restraint use that cover (a) | An appropriate restraint minimisation committee/group is established |

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| <p>(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.</p> | | <p>and enabler use. 'Restraint' is an agenda item on the quality and risk committee meetings agenda; however, in the minutes reviewed there was no documentation of any discussion on this (Refer 1.2.3.5). It was clear from interviews with the restraint coordinator that restraint use is minimised with the one restraint in use appropriate to maintain the safety of the resident.</p> | <p>to (h) of the standard are not occurring as required.</p> | <p>and completes monitoring and quality review of restraint minimisation practices to meet the requirements of the standard.</p> <p>180 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 |
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| Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met. | CI | Routine weight monitoring showed that group of residents had either unexplained weight loss, or no weight gain over time. Investigation showed that several patients with dementia were not eating enough at meal time and often left the dining room before the second course was out. As a result, a programme was implemented, with the support of the dietitian and residents’ families. The programme consisted of four residents who were given a clear lunchbox after breakfast containing high protein and high nutrition snacks such as protein bars, muffins, cheese, boiled eggs, yoghurt, etc., to have with them to allow them to graze all day. Families were encouraged to bring in favourite snacks and treats as well. Over a period of four months, three of the four residents gained between 2-6% of their body weight, while the fourth resident’s weight remained stable. One resident was noted to be more responsive and engaging. It was noted that fewer falls occurred and infection rates reduced amongst the participants, though documentation of this was not sighted. | Residents who had experienced weight loss were provided with lunch boxes of high protein and nutrient snacks to stimulate eating throughout the day and as a result consistent steady weight gain and no further weight loss was noted. This was substantiated in data provided. In addition, it was noted that fewer falls occurred, and infection rates reduced amongst the residents in the programme. |

End of the report.