# Orewa Beach View Retirement Home & Hospital Limited - Solemar

## 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 Q-Audit 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Orewa Beach View Retirement Home & Hospital Limited

**Premises audited:** Solemar

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

**Dates of audit:** Start date: 6 April 2021 End date: 7 April 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:** 25

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## Solemar provides dementia, rest home and hospital level of care for up to 30 older people. There were 25 residents at the time of audit, (11 hospital, one rest home and 13 dementia. Residents and families report satisfaction and positivity about the care, services and activities/lifestyle options provided. The facility manager (FM) has been running the service since 2017 with the assistance of the clinical manager (CM). There have been no significant changes to the facility or services since the last audit.

## This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included a review of policies and procedures, the review of residents’ and staff files, observations and interviews with residents, relatives, staff, and management.

## This audit resulted in three identified areas requiring improvement relating to adverse events, good practice, and service delivery interventions.

## Consumer rights

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |

The Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents and residents family members when they enter Solemar. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Solemar are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

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

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

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

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

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |

The organisation is governed by the owner/director supported by the other co-owner/director. The operation of the facility is undertaken by a facility manager (FM) who is supported by a clinical manager (CM). Organisation performance is closely monitored by the FM and owner/directors.

Business and quality plans include the scope, direction, goals, values, and mission statement of the organisation. The business, quality risk and management plan document the organisation’s goals and objectives. Effective reporting processes are in place. The organisation’s quality and risk management system are used to ensure service delivery is of a consistently high standard. It includes an audit programme and corrective actions are developed and implemented when deficits are identified.

These are monitored, and the management ensure all data is analysed, collated, and shared with staff. Adverse events are reported and recorded. Policies and procedures are current. Established processes are in place to facilitate client entry to and exit from services. Residents’ information is managed efficiently, contains a level of detail relevant to the service and meets health record requirements.

Human resource processes support good employment practice. All staff receive an orientation. Ongoing training is provided, and staff competencies are assessed and monitored. Current annual practising certificates are kept on file. Police checks are undertaken. There are always adequate numbers of skilled staff on duty.

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

## Continuum of service delivery

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |

The staff at Solemar work closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/residents’ family members/whanau of residents to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

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

The planned activity programme is provided by a diversional therapist. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A van is hired when required for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and family members of residents verified overall satisfaction with meals.

## Safe and appropriate environment

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

Solemar is a well-maintained home like setting with all residents having individual bedrooms decorated with personal belongings. All rooms had adequate natural light, ventilation, and heating. The facility meets the needs of aged residents including the residents assessed as requiring dementia level of care.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness which expires on 03 April 2022. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has implemented policies and procedures that support the minimisation of restraint. There were three residents using restraint and no enablers, at the time of audit. Use of enablers is voluntary and for the safety of the residents, in response to individual requests. A comprehensive assessment, approval and monitoring process with review occurs. Staff have knowledge and competency regarding the restraint and enabler policy and processes.

## Infection prevention and control

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

The infection prevention and control programme aim to prevent and manage infections. The programme is reviewed annually. Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with online education. Aged care specific infection surveillance is undertaken and analysed. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 47 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 0 | 98 | 0 | 0 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment rating** | **Audit evidence** |
| 1.1.1: Consumer Rights During Service Delivery.  Consumers receive services in accordance with consumer rights legislation. | FA | Orewa Beach View Retirement Home & Hospital (Solemar) has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed. Ongoing training on the Code was last provided in August 2019, as evidence by training records and interviews (refer criterion 1.1.8.1). |
| 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidelines to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisations standard consent form including for photographs, outings, invasive procedures, and collection of health information.  Advanced care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent are defined and documented where relevant in the residents’ file. Staff demonstrated their understanding by being able to explain situations when this may occur.  All resident files reviewed in the secure unit had specialist authorisation for placement and an activated EPOA in place.  Staff were observed to gain consent for day-to-day cares on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed in the facility, and additional brochures were available at the entrance. Family members of residents spoken with were aware of the Advocacy Service, how to access this and their right to support persons.  Staff were aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | 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’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints management policy and procedures in place that align with the code. The services complaints register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been resolved. There was only one complaint in 2020 and none so far in 2021. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and family are advised of the complaints process on entry to the service. This includes written information around making complaints. Residents interviewed describe a process of making complaints that includes being able to raise these when needed or directly approaching staff or the facility manager. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and resident’s family members at interview reported being made aware of the Code and the Nationwide Health and Disability Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and resident’s family members confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. There is a double room in the hospital/rest home unit that is used as a double room for couples. This was vacant at the time of the audit. All other residents have a private room. Monitored CCTV surveillance operates in public areas throughout the facility. Signage at each front entrance notifies anyone entering the facility that this is operating.  Residents are encouraged to maintain their independence by participating in activities of interest, assistance to maintain past lifestyle patterns and interests and regular outings to areas of interest. Each care plan included documentation related to the residents abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious, and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff. Ongoing training on abuse and neglect however has not been provided since mid-2018, as confirmed by interviews and training records (refer criterion 1.1.8.1). |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There was one resident and two staff members at Solemar at the time of the audit who identify as Māori. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Evidence of a Māori health care plan being implemented was sighted in the file reviewed. Interview with the resident’s family member verified the cultural considerations required regarding this resident, were being met by the staff at Solemar. Additional cultural advice is available through the palliative outcome initiative through the Harbour Hospice should it be required. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and their family members verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Residents’ personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. A resident who identified as being of another culture was included as one of the eight files reviewed. A cultural assessment and care plan was sighted that reflected the specific cultural needs of this resident. Interviews with staff verified that consideration of these needs was included in the daily care provided. Contact with this residents’ family member was not available at the time of audit. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that the residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to the residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | PA moderate | The service encourages good practice in a homely environment that provides individualised and respectful care. This was verified by interviews with family members of residents. Staff were noted to be caring, respectful and always willing to help. Management was also noted by family members to be helpful and prompt when approached regarding any areas they sought advice on.  Solemar promotes good practice through its use of evidence-based policies provided by an external advisory company. The clinical manager (CM) however, has no documentation on file to verify recent training on up-to-date best practice guidelines in a range of areas requiring her oversight at Solemar. This is an area requiring attention.  Input from external specialist services and allied health professionals is available in such areas as: gerontology nursing services at the Waitemata District Health Board (WDHB), physiotherapy, wound care, and mental health services for older persons. Registered Nurses (RN’s) from Solemar can access training through the Residential Aged Care Integration Programme (RCAIP) that meets bimonthly, and the facility subscribes to an online training programme accessible to staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members of residents stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ family communication records. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via WDHB when required. A resident with English as a second language was able to communicate with assistance from family and cue cards, for key words, provided by the family. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The business, quality risk and management plan include the scope, direction, goals, values, and mission statement of the organisation. The owner/director visit the facility every week to meet up with FM and CM and other issues are discussed as they occur on a regular basis. The business, quality risk and management plan are current. The owner/director reported that the service was certified for 30 beds, with one room that can be used as a double room.  The documents describe annual and long-term objectives and the associated operational plans. The FM reports to the owner/director. Monthly reports to the owner/director showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, growth and development, maintenance, quality management and financial performance.  The FM is supported by the CM and owner/directors. The management team meets daily where regular updates are reported to the FM by the CM. All members of the management team are suitably qualified and maintain professional qualifications in management, and clinical skills. The FM and CM have vast experience and knowledge in the health sector. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The owner/director interviewed reported that there are planned renovations, and maintenance of the external walkways and the laundry area.  The service holds contracts with the district health board (DHB), ministry of health (MOH) for the provision of rest home, hospital, dementia care and long-term support chronic health conditions (LTS-CHC). There were 25 residents receiving services on the days of the audit. At the time of audit there were (11) hospital level residents, one (1) rest home level and (13) secure dementia level care residents, respectively. |
| Standard 1.2.2: Service Management  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. | FA | When the FM is absent, the CM allocated to the role carries out all the required duties under delegated authority with support from the owner/director. During absences of key clinical staff, the clinical management is overseen by a selected senior RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents and accidents including infections surveillance.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. The FM reports to the owner/directors monthly. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly however the response rate has been low in the past years and evidence of this was sighted.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes.  The FM described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The FM and owner/director are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA moderate | There are documented policies and procedures on adverse event reporting. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively.  The FM described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.  An improvement is required to ensure all adverse events are investigated, documented and family/whānau notified in a timely manner. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staff files sampled show appropriate employment practices and documentation. Current annual practising certificates are kept on file. Police checks are undertaken. 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 providers agreement with the DHB. Only one RN is interRAI trained and competency assessments were sighted in files sampled. The orientation/induction package provides information and skills around working with residents with dementia, rest home and hospital level care needs. Staff reported that they receive ongoing training to meet the needs of residents requiring dementia level of care. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. Staff training on consumer rights, infection control, palliative care and areas that require clinical manager oversight could be improved (refer to 1.1.8.1).  Residents and family interviewed stated that staff are knowledgeable and skilled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe delivery, 24 hours a day, seven days a week. The service adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when required. Care staff reported there were adequate staff available to complete the work allocated to them. Observations and review of a four -week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All shifts have a staff member on duty with a current first aid certificate and the CM covers during the day. Two health care assistants are always in the secure dementia service and hospital wing supported by either the CM or RN. There is a registered nurse on 24/7 to cover this facility. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | A resident register of all current and past residents is maintained. The resident’s name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered in the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived paper records are held securely on site and are readily retrievable using a cataloguing system. Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are admitted to Solemar when their required level of care has been assessed by the local Needs Assessment and Service Coordination (NASC) Service.  Residents receiving care in the secure unit have a specialist’s authorisation for placement in the unit, in their file. All files reviewed of residents receiving care in the secure unit have an activated EPOA in place. Consents and admission agreements in files reviewed of residents in the secure unit have been signed by the EPOA.  Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the CM. They are also provided with written information about the service and the admission process.  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. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the WDHB ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.  There were no residents at Solemar who self-administer medications at the time of audit.  Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used at Solemar.  The GP verified minimal use or PRN medication at Solemar to manage behaviours that challenge. This was verified in the medication file reviews. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a cook 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 in March 2021. Recommendations made at that time have been implemented.  A verification audit of the Food Control Plan was undertaken on15 March 2021, by the Auckland City Council. Six areas requiring corrective action were identified. These are evidenced to have been attended to and were being submitted (as agreed) by the 15 April 2021. When the evidence is accepted, documentation verifies an 18-month verification is to be approved.  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cooks have undertaken a safe food handling qualification.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is available.  Residents in the secure unit have access to food twenty-four hours per day.  Evidence of resident satisfaction with meals is verified by resident’s weight records, observation, family members interviews and satisfaction surveys. An interview with the cook identifies any areas of dissatisfaction evidenced by food not being eaten was promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  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 | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently 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 whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission residents of Solemar are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.  In all files reviewed initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident’s condition changes. Interviews, documentation, and observation verify that the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.  All residents have current interRAI assessments completed by one trained interRAI assessor on site. InterRAI assessments are used to inform the care plan.  All files reviewed of residents in the secure unit had a behaviour assessment that identified behaviours that were particular to each resident, in addition to an assessment that identified individual diversional and recreational requirements.  A resident in the secure unit, was noted to have a decrease in mobility, and the possibility of the need to remain in the unit was questionable. On the day of audit, a request for a review of placement was made to the NASC by the CM. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Except for that referred to in criterion 1.3.6.1, plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans evidenced service integration with progress notes, activities note, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.  All files reviewed in the secure unit had a behaviour management plan that included prevention-based strategies to minimise episodes of behaviours that challenge, triggers to behaviours and de-escalation strategies to manage those behaviours. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA moderate | Documentation, observations, and interviews, verified the provision of 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 except for managing the potential risk and presence of pressure injuries and the management of wounds. This is an area requiring attention. 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. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. The exception to this relates to wound care. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by a trained diversional therapist.  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 regularly and as part of the formal care plan review every six months.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included an exercise programme, pet therapy, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed with family members on a one-to-one basis. Satisfaction with the activities programme offered at Solemar was verified by interview with resident’s family members, observation, and satisfaction surveys.  Residents in the secure unit have a twenty-four hour activity/care management plan in place, that covers twenty-four hour needs and past lifestyle practices. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the CM/RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care.  Behaviour management plans are evaluated to include a review of the plan’s effectiveness. Short term care plans are used for a range of problems where deviations from the individuals normal occurs for example, infections, pain, weight loss, medication changes, skin rashes, and progress evaluated as clinically indicated. Residents’ family members/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| 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. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the RN or the GP. The residents family member is kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The owner/director is responsible for minor maintenance issues while other requirements are externally contracted. The service uses liquid petroleum gas (LPG) for cooking, the cylinders are stored outside the kitchen area and test certificate was current. Staff responsible for cleaning have completed the required chemical handling training and ensure adequate stock is held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A spill kit is available and accessible if needed.  There is provision and availability of protective clothing and equipment and staff were observed using them. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is publicly displayed. Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with owner/director and observation of the environment.  The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. Residents’ rooms have direct external access to courtyards and garden areas. There are ramps to enable disability access. Residents can walk around freely throughout the facility and grounds which are securely protected. External areas are safely maintained and are appropriate to the resident groups and setting.  Residents and family/whānau confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned and that they are happy with the environment. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. This includes the hospital/rest home and secure dementia unit. Communal toilets and showers have a system that indicates if they are vacant or occupied. These bathrooms are situated near the residents` own rooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. There are eight rooms with ensuite bathrooms/toilet and vanities in secure dementia unit and four rooms with own ensuites in the hospital/rest home wing. Records of hot water temperatures are maintained to ensure that the water remains at a safe and consistent temperature. Visitor and staff toilet is available at the facility. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are 29 single bedrooms with a toilet and hand basin and one double room. Personal privacy is maintained. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, hoists, and wheelchairs. The facility has two hoists, a standing and a sling hoist. Manual handling training is mandatory for all staff. Staff and residents confirmed the adequacy of bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available for residents to engage in activities. The dining rooms/lounge both in the secure dementia unit and hospital/rest home wing. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry such as bedding, and towels is washed off site by a contracted provider and personal laundry is washed on site or by family members if requested. Family/whanau interviewed expressed satisfaction with the laundry management and that clothes are returned in a timely manner. There are designated cleaning personnel who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A spill kit is available if required. Material data sheets are available in the laundry and the sluice room for staff to access when required. Cleaning and laundry processes are monitored through regular feedback from staff and family/whānau, internal audit programme and corrective actions are acted upon.  Care staff demonstrated a sound knowledge of the laundry processes. There is clear separation of clean and dirty areas in the laundry. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The most recent fire drill was conducted on 24 March 2021. The orientation programme includes fire and evacuation. Staff confirmed their awareness of the emergency procedures.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, and gas for cooker/barbecue, were sighted and meet the requirements for the 25 residents at the service. There is a 4000-litre water tank onsite also available if needed. There is closed circuit television (CCTV) and the side gates to the facility are always closed. Evening and night-time security is managed by the staff. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | 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. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required in residents’ rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  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. | FA | Solemar provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisory company.  The infection control programme is reviewed annually.  The CM is the ICC whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM, and tabled at the staff and management meetings. Infection control statistics are entered in the organisation’s infection database. The organisations owner is informed of any IPC concern.  Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has minimal skills to implement the ICC programme (refer criterion 1.1.8.1), however is guided by policies implemented by an external advisory company and recent advice regarding Covid-19 by the projects manager from the WDHB. The WDHB provided onsite training to the CM on the correct use of personal protective equipment (PPE), and this has been passed on to staff by the CM.  The coordinator has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  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. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.  Care delivery, cleaning, laundry, and the cook were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. This however was not evidenced in the kitchen, where care staff were required to work in the kitchen washing residents’ dishes, in between attending to residents’ care needs (refer criterion 1.1.8.1).  Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have not consistently received education in IPC at orientation (refer criterion 1.1.8.1). Ongoing education sessions are offered via an online training hub. Content of the training was documented. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.  Education with residents is difficult and 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICC/CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation’s infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is compared against previous years.  A good supply of PPE is available. Solemar has processes in place to manage the risks imposed by Covid-19. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies which guide the use of restraints and enablers, these align to sector standards. Enablers are used to promote resident safety and independence with resident and/or EPOA consent as appropriate. There were no enablers in use during the audit and there were three residents using restraint. The restraints in use included lap belts and bed rails. Clinical files reviewed confirmed written consent was in place for the use of all enablers and restraints. The restraint and enabler registers were sighted, along with documentation of observations and review of the use. Staff receive training in challenging behaviour. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The restraint policy is comprehensive and documents the approval process, including the indications, consent, duration, and monitoring requirements. The FM discusses restraint use with the CM, GP, family, and resident. The FM oversees and coordinates the use of enablers and restraints in line with the policy. The facility manager was interviewed and was familiar with the standards requirements and the facility’s policy. Documentation was sighted that confirms restraint use was assessed, minimised, and reviewed. Staff interviewed confirmed they received restraint and enabler training and were able to outline the policy. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Records sighted confirmed the initial assessment was performed by the facility manager, prior to being further assessed for restraint use. The assessment tool included identification of the risks and interventions to be used to promote resident safety, and frequency of checks. The resident and/or the resident EPOA in involved in the initial assessment and ongoing evaluation of restraint use. There were three restraints in use during the audit. The clinical files were sampled, the use of restraint was documented in the care plans and interRAI assessments. Family members of residents using restraints confirmed they had been involved in assessment and ongoing review of the restraint. Staff interviewed were aware of the restraint process and were aware of the residents documented care interventions relating to restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register was sighted that detailed required information, including the reason for the restraint and the desired outcome. The care plans reviewed documented the interventions required to facilitate the safe use of the restraint. Restraint monitoring forms were completed. Evidence was sighted that the residents and/or the EPOA or family (as appropriate) were involved in the ongoing review of the use of restraints. Restraint consent forms were signed by the resident and/or EPOA, the restraint co-ordinator and the GP. Family members interviewed confirmed they had participated in discussions regarding the use of the restraint and understood the rationale, risks, and benefits of its use. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Regular reviews are conducted on residents with restraints, and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring, and any change required. Staff and family/whānau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint and the risk management plans were documented in the long-term care plans. Evaluation time frames are determined by the risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint reviews occur six monthly of all restraint use which includes all the requirements of the standard. The FM reported discussions around minimising use of restraints are ongoing. Minutes of meetings were reviewed, and confirmed this includes analysis and evaluation of the amount and type of restraint considered, the effectiveness of the restraint in use for each resident, the competency of the staff and the appropriateness of the restraint/enabler education provided and feedback from family, the GP, and staff. Restraint updates are routinely included in the monthly staff meetings and in monthly reports to the owner/director. Any changes to policies, guidelines, education, and processes are implemented if indicated. |

# 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.

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| **Criterion with desired outcome** | **Attainment rating** | **Audit evidence** | **Audit finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | PA Moderate | The CM has no documentation on file to verify competency to manage a range of clinical situations that are presented at Solemar. The CM is the only RN who is interRAI trained and is required to complete all interRAI assessments. The CM can attend the RCAIP training, however, this requires a relief RN to be onsite at Solemar for attendance by the CM to occur. The additional four RNs at Solemar are new graduates and often require training and attendance at these sessions themselves. The CM or RNs have no verified up to date knowledge of wound care management (refer criterion 1.3.6.1).  The CM is the infection control coordinator (ICC) and although has access to policies on infection control (IC) provided by an external agency, has no formal training or knowledge on managing an infection control programme (refer criterion 3.4.1). Care staff currently work in the kitchen doing dishes, in between attending to residents’ care needs. No attention to infection control consideration is in place around this practice. Orientation of new staff does not include input from the CM/ICC regarding infection control practices at Solemar.  There has been no staff training on Consumer Rights since August 2019, or abuse and neglect since mid-2018.  There are no RNs at Solemar who are competent in syringe driver use. An interview with the director, verifies that on its website Solemar, does not offer palliative care. There are, however, no RNs qualified to support any present residents at Solemar who may require palliative care in the future. | There is no documentation on file to verify recent training on up-to-date best practice guidelines, in a range of areas requiring clinical manager oversight at Solemar. | Provide evidence the clinical manager is enabled the opportunity to attain the skills, support, and expertise to ensure an environment of good practice can operate.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were not fully completed, incidents were not being consistently investigated, action plans developed, and actions followed up in a timely manner. There is an open disclosure policy in place. Communication with family following an incident could be improved. In interview conducted with general practitioner (GP) confirmed being notified following adverse events and if there is any change in the resident’s condition and this is recorded in the residents’ records. | Six (6) incident/accident forms sampled had not been fully completed regarding investigations, action plans | Ensure adverse events are consistently investigated, documented and family/whanau notified.  90 days |
| 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA moderate | The provision of interventions at Solemar is consistent with meeting the residents assessed needs, except for pressure area prevention, pressure area management and wound care management.  Three of five hospital files reviewed had documentation confirming the presence of stage two facility-acquired pressure injuries. One of the other two files had an ongoing pressure area that heals and then breaks down again. The management of these areas was not consistent with up-to-date best practice guidelines. Dressing choice was limited with limited wound care knowledge to support a change in products. Photographs and documentation verified minimal improvement is occurring. No nutritional support was included in the wound management plan. On the day of the audit, photos were emailed to the wound care nurse specialist to seek advice on recommended dressing regimes. There was no detailed turning regime for these residents.  No analysis or review had occurred regarding what strategies could have been implemented to prevent these pressure injuries occurring. A pressure injury assessment on admission had identified the high level of risk. Pressure relieving mattresses were in place. Turning regimes were not specific. Residents were observed to have remained sitting in lazy boy chairs all day without position changes.  The facility had 22 wounds in eleven residents. While most of these were superficial, the dressing choices were not consistent with best practice and promoting wound healing, and the healing process was slow.  No attention to increased nutritional needs was included in the wound management plan. | The management of residents at potential risk of pressure injuries, those that develop pressure injuries, and management of resident’s wounds is not consistent with meeting the residents desired outcomes or best practice standards. | Provide evidence of training in pressure injury prevention and management. Provide evidence of up-to-date wound care training. Provide evidence of a commitment in the reduction of facility acquired pressure injuries.  60 days |

# 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.

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End of the report.