

The Napier District Masonic Trust - Taradale Masonic Residential Home & Hospital

Introduction

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

The audit has been conducted by 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](#).

The specifics of this audit included:

Legal entity:	The Napier District Masonic Trust
Premises audited:	Taradale Masonic Residential Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 July 2021 End date: 23 July 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:	67



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Taradale Masonic Home and Hospital provides rest home and hospital care for up to 74 residents. The service is operated by The Napier District Masonic Trust and is managed by a general manager and a clinical manager. Residents and families interviewed 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 Hawkes Bay District Health Board (HBDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, staff, contracted health providers and a general practitioner.

The audit has resulted in no areas identified as requiring improvement. Two continuous improvements have been provided in relation to health and safety hazard identification and emergency management processes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

Care for residents who identify as Māori is guided by a comprehensive Māori Health Plan and related policies.

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

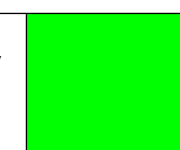
Open disclosure between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services or translation services if required.

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

Families are supported and encouraged to visit, with effort put into maintaining family involvement in care planning, lifestyle choices and activities. Residents can participate and have involvement in community activities. Residents expressed appreciation of the respect for individual spiritual beliefs and the variety of activities provided.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management plans include the scope, direction, mission statement and values of the organisation. Monitoring of the services provided and reporting to the Napier District Masonic Trust Board is regular and effective. The facility is managed by the general manager and an experienced clinical manager. Additional staff have roles such as the property and maintenance manager and education and quality coordinator and all report to the board.

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

The appointment, orientation/induction, and management of staff are based on good practice. A systematic approach to identify and deliver ongoing education supports safe service delivery and includes regular performance review for all staff. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people. Archived records can be retrieved as needed. Staff and resident records are maintained using integrated hard copy and electronic records.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The admission process is efficiently managed by the administration manager with relevant information provided to the potential resident/family. Each stage of service provision is provided by suitably qualified personnel in a timely manner. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The files reviewed demonstrated that the care provided met the needs of the residents and relevant people including residents and family, were consulted where appropriate. 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.

The medicine management system implemented complies with legislation, protocols, and medicine guidelines.

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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are processes for managing waste and storage of any chemicals used on site. The building warrant of fitness is current and displayed at reception. Electrical equipment is tested, and calibration of all medical equipment occurs as required.

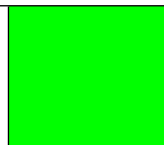
Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry and cleaning is completed on site. Chemicals, soiled linen and equipment are safely managed. Products used are managed for effectiveness. The facility meets the needs of residents and was clean and well maintained. The property manager and maintenance team are responsible for the maintenance of the facility.

Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. Fire evacuation procedures are regularly practised. A nurse call bell system is in place for residents to summon assistance. Security is maintained.

Restraint minimisation and safe practice

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

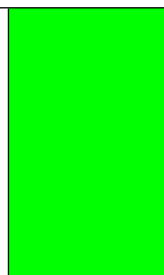


Standards applicable to this service fully attained.

There are clear and detailed documented guidelines on the use of restraints and management of challenging behaviours. There were twelve residents using restraint on the days of the audit. Staff interviewed demonstrated a good understanding of restraint use and receive ongoing education in restraint, challenging behaviours, and de-escalation techniques through in-service training.

Infection prevention and control

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



Standards applicable to this service fully attained.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise any risk of infection to residents, staff and visitors. 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.

The type of surveillance is appropriate to the size and complexity of the service. Infection data is collected, recorded, analysed and results reported through all levels of the organisation. Follow-up action is taken as and when required. There was no infection outbreak reported since the last audit.

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	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Taradale Masonic Home and Hospital 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 demonstrated respectful communication that encouraged independence, provided options, facilitated informed choice and at the same time-maintained dignity, respect and privacy at all times. Training in the Code is included as part of the orientation process and is part of the ongoing education which was verified in the training records reviewed. Staff demonstrated understanding of the various cultural and spiritual beliefs held by residents.</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</p>	FA	<p>Management, nursing, and care staff interviewed understood the principles and practice of informed consent. Informed consent policies reviewed provide guidance to staff. The clinical records reviewed demonstrated that informed consent has been gained appropriately using the standard consent form including for photographs, van outings, procedures and collection and retention of health information.</p> <p>Advance care planning, establishing and documenting EPOA requirements and processes for residents unable to provide consent are defined and documented where relevant in the residents, record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day-to-day care and activities on an ongoing basis.</p>

consent.		The service does not store or use body parts or bodily substances.
<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>When residents are admitted to the service the residents/ families are provided with an information pack and included is a copy of the Code, which also includes information on the Nationwide Advocacy Service. Posters related to the Code were also displayed in the facility. Additional brochures on the Code and advocacy service were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their individual right to have support persons of their choice.</p> <p>Staff interviewed were aware of how to access the Advocacy Service if needed. The contact numbers of advocates for this region were documented on the reverse of the Code pamphlet sighted.</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 and to maintain links with their local community. Mostly in conjunction with the activities programme developed and implemented.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they always felt welcome when they visited the facility and comfortable with their dealings with staff.</p> <p>Residents can be supported by staff or a support person to attend outings in the community as needed.</p> <p>There is evidence of family involvement in the records and from comments made by family and residents at interview.</p> <p>The diversional therapist and activities coordinators are very focused on residents being able to maintain their skills and contacts with the local community. The activities planner is displayed in all service areas of the facility. There is an extensive range of activities residents can choose from, including individual activities for those that prefer this rather than large group activities.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints/compliments policy reviewed meets the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families when the resident is admitted to this service and those interviewed were well informed. Compliments are acknowledged and fed back to staff.</p> <p>The complaints register reviewed demonstrated that four complaints have been received in the last 12 months and that actions were taken through to an agreed resolution and completed within the required timeframes. The four complaints followed through were effectively closed out signed and dated. Improvements were made where possible for quality improvement. The clinical manager is responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. All</p>

		complaints are reported to the general manager (GM) and discussed at the board meetings held monthly.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the entry to service information and discussion with staff. The Code is displayed in and around the facility. Brochures on the Code, information on advocacy services, how to make a complaint and feedback forms were available in the various entrances to all services.
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	<p>Residents and families confirmed at interview that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring information is held securely and confidentially and when exchanging verbal information and during discussions with families, the general practitioner (GP) and other specialist service providers. All residents have their own room.</p> <p>Residents are encouraged to maintain their independence by participating in activities in the community and regular outings to places of interest. Each care plan included documentation related to the resident's individual abilities and strengths to maximise independence.</p> <p>Records reviewed confirmed that resident's cultural, religious, social needs, values and beliefs had been identified on admission, documented, and incorporated into their individual care plans.</p> <p>Staff understood the service's policy on abuse and neglect. Staff interviewed understood their responsibilities should there be any signs of abuse and neglect. Education is provided at orientation and is part of the ongoing education programme for all staff provided annually. In-service and training records were reviewed.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability	FA	There were two residents in Taradale Masonic Home and Hospital who identified as Māori. Evidence including resident interviews, verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice. Whanau are encouraged to participate and to visit regularly. There is a current Māori Health Plan developed and implemented across the organisation with input from cultural advisors. Advice is sought as required to ensure cultural expectations by some families/whanau whilst considering the needs and comfort of all residents.

<p>needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>Tikanga best guidelines are available to guide staff and are supported by staff who identify as Māori in the facility. The Māori residents and their whanau interviewed reported that staff acknowledge and respect their individual cultural needs. One resident who identified as Māori recently received a recognition award presented at this home with 100 people in attendance for his work in the community prior to admission.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents interviewed stated that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences required interventions and any special needs were included in all care plans reviewed, for example food likes and dislikes, times of showers to be undertaken, preferences to activities they preferred and were interested in participating. Family and staff interviewed verified staff of similar cultures to residents assisted them where required. Interpreter services are used if needed.</p> <p>Staff interviewed showed an understanding of diversity. They noted the number of different nationalities working at Taradale Masonic Home and Hospital that they can utilise to provide culturally appropriate service delivery. Residents reported being asked about their ethnic identity. Residents commented that their preferences are attended to. Family interviewed reported being consulted regarding their family member's beliefs and interests.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe and secure. A GP interviewed also expressed satisfaction with the standard of services provided at Taradale Masonic Home and Hospital.</p> <p>The staff induction process for staff includes education related to professional boundaries and expected behaviours. Registered nurses (RNs) have completed the required training for the New Zealand Nursing Council on professional boundaries over the last two years. Staff are provided with a Code of Conduct as part of the individual employment agreement (IEA). Education is provided annually both elective and mandatory for all staff. Topics such as abuse, neglect and professional boundaries are provided for on-going learning purposes. Staff training records are maintained. Staff are guided by the organisations policies and procedures, and when interviewed demonstrated a good understanding of what would constitute inappropriate behaviour and the processes, they would follow should they suspect this was occurring.</p> <p>Residents and family interviewed stated they felt this is a safe service and had not ever witnessed nor experienced any staff behaviour that could be constituted as discriminatory, abusive, neglectful, or inappropriate. Residents reported staff are supportive, helpful, and kind. Should staff refuse any aspect of treatment, staff reported they would still be able to access all support and other treatment options. There were no instances cited or recorded where this has occurred nor any indication this would be the case based on staff/resident interaction.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Management at Taradale Masonic Home and Hospital encourage and promote good practice through evidence-based policies, input from external specialists as required for resident's health and wellbeing. The GP interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for ongoing education, to access professional networks and on-line learning packages to support contemporary good practice.</p> <p>The service promotes good practice through its policies and procedures guiding service delivery, comprehensive documentation and approval processes and evidence-based training. Best practice is maintained by staff education and from the close relationship with health professionals in the multidisciplinary team. The GP interviewed acknowledged the quality of care provided to the residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents, relatives/representatives with enduring power of attorney (EPOA) stated they were kept well informed about any changes to their own or their relative's health status and were advised in a timely manner about any incidents that may have occurred or any urgent medical reviews. This was well supported in residents' individual records reviewed. There was evidence of resident/family/EPOA input into the care planning process and regular multidisciplinary reviews. Senior staff interviewed understood the principles of open disclosure. The policy sighted meets the requirements of the Code.</p> <p>Interpreter services are able to be accessed through the district health board (DHB) if required. Several staff members were able to support residents where English was their second language and interpreter services were rarely needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The governance organisational structure was reviewed. Level one is currently under review. The organisation has two aged care facilities and both report to the Napier District Masonic Trust Board which comprises of eleven (11) trustees on the board and an appointed chairperson. The latest chairperson was elected February 2021. The GM has been in the role since 2009. The clinical manager is currently the chairperson of the board. There are four long term trustees on the board currently with the knowledge of the organisation and the sector. Free Masons on the board represent Lodges in the region. The mission statement and values are clearly displayed at the entrance to Napier Masonic Home and Hospital at reception. The objectives for the organisation are reviewed annually but the plan is developed through to 2025. Reports are provided to the monthly board meetings inclusive of financial, property management, clinical, quality, human resource management, education, and updates and/or of any issues. Any incidents are notified prior to the board meeting. The education and quality coordinator report sighted covered education, compliments, health, and safety/ Section 31 notices if any, incident data for both facilities, SAC reports, infection control, interRAI updates and care planning, internal audit outcomes and any areas identified for improvement. Any risks identified are transferred to the organisation's risk register and/or updates are made to the register. The last board meeting was held 02 July 2021 and minutes of the meeting are</p>

		<p>maintained.</p> <p>The service is managed by a clinical manager who holds relevant qualifications and has been at this facility since the 16 March 2020. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through relevant courses and events related to aged care and other topics of interest. The clinical manager reports to the GM regularly and is supported by the recent appointment of the education and quality coordinator who is experienced in the aged care sector.</p> <p>The service holds contracts with the DHB for rest home and hospital level care, young person disabled (YPD) under 65 years, long term support chronic health care (LTSCHC), Restore (Engage), respite, mental health, accident compensation corporation (ACC) and occupancy right agreements (ORA). On the first day of audit there were sixty seven (67) residents. This included one LTCHC (RH level), one resident YPD under 65 years, one resident under the Restore (Engage) contract, Respite care- nil, one ACC and Nil ORAs (there is a total of six ORAs available). Thirty seven (37) rest home residents and 30 hospital level care residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the clinical manager is absent, the education and quality coordinator is available to carry out all the required duties under delegated authority. The clinical coordinator is also available to assist with any clinical issues that may arise. Senior registered nurses are available to assist the clinical coordinator on a daily basis. Four senior staff (RNs) would cover the service after-hours.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, complaints, internal audit activities, regular satisfaction surveys, monitoring of outcomes, clinical incidents including infections, restraint minimisation and safe practice. The internal audit system has been developed and implemented for 2021.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk management monthly meetings. Staff reported their involvement in quality and risk management activities through audit activities. The education and quality coordinator ensures</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>relative corrective actions are developed and implemented to address any shortfalls. The programme has been set for the staff meetings held during the year such as health care assistant meetings two monthly, kitchen staff meetings held two monthly, RN and enrolled nurse meetings monthly, support staff two monthly and bi-monthly education and diversional therapy meetings also occur. The management meeting is held monthly prior to the board meetings. Minutes are maintained of all meetings held and these were reviewed. Multidisciplinary team meetings are held weekly as a 'Wednesday Huddle') a forum to discuss residents, reassessments, referrals to the DHB or any issues plus other staff meetings occur as documented and planned for the year.</p> <p>Annual resident/family surveys are completed annually. The June 2020 survey was reviewed with positive feedback provided. The 2021 resident/family survey is yet to be completed. The staff survey was completed June 2021 and results have been presented and reported to the board including an analysis of the last two years. Any areas of improvement are acknowledged and included in the quality improvement plan for the service. The service is planning and leading into using a survey monkey methodology for the next survey period.</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. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval by the board, if necessary, distribution and removal of obsolete documents. The system is being managed by the education and quality coordinator. When necessary, the GM signs off any new policies.</p> <p>The clinical manager and the education and quality coordinator are familiar with the Health and Safety at Work Act (2015) and ensure the implementation requirements are effectively managed. Training is provided to all staff annually on the quality and risk management system requirements. The service has an up-to-date risk register. A continuous improvement was allocated in relation to the health and safety hazard and risk identification (refer to 1.2.3.9) of an infection control and environmental issue that required immediate action to ensure the risk of injury/harm to a resident was eliminated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice</p>	<p>FA</p>	<p>Policies and procedures and a flow chart are accessible to guide staff on all aspects of incident/accident and adverse event reporting. A sample of incident forms reviewed showed these were fully completed. Incidents were investigated, action plans developed and actions followed-up in a timely manner. All incidents are logged into the electronic system and the hard copy log in each resident's individual record, is maintained and kept up to date. The clinical manager is responsible for maintaining the data base. On a monthly basis the incident/accident data base is printed off the electronic system and the information is placed into the clinical report. This includes data on the number of falls, skin tears, infections, damage to property, equipment faults and medication errors, security, and safety. The clinical manager collates the information, analyses and reports the outcomes and any trends identified to the education and quality coordinator. Any trends are fed back to the staff at the quality meetings held monthly.</p>

in an open manner.		The clinical manager, education and quality coordinator and clinical coordinator described essential notification reporting requirements, including for pressure injuries. There have been two Section 31 Notices completed this year so far, one in January and one in July. One notice was related to a stage 3 pressure area and one a serious event. In addition to this one recent event led to the New Zealand Police being involved and a Section 31 was sent off to HealthCERT on the day of the audit.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management policies and processes are based on good employment practice and relevant legislation A sample of staff records reviewed confirmed that the organisation's policies are being consistently implemented and records are well maintained by the human resource manager, supported by the clinical manager. The recruitment process does include referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required.</p> <p>Staff have two folders each, one for initial application, interview records, acceptance letters and curriculum vitae (CV) and the other folder for education records and certificates, job descriptions, the individual employment agreement and appraisal records. Staff checklists and new initiatives are completed on the front of each staff record folder.</p> <p>Staff orientation/induction booklets include all necessary components relevant to each role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance appraisal after a three-month period and annually. Records reviewed demonstrated all staff had completed the required training and annual appraisals were verified.</p> <p>Continuing education is planned annually and includes all mandatory training requirements. The training plan for 2021 was sighted. The education quality coordinator maintains an electronic spreadsheet of all education completed for each staff member. Health care assistants (HCAs) have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the service provider's agreement with the DHB. Approximately fifty one (51) HCAs are employed permanently plus some casual HCAs are available for relief shifts when needed. Currently thirty five (35) have completed level 4, twelve (12) level 3, four level 2, three are enrolled for 2021 and approximately five are yet to complete any external training. There are sixteen (16) registered nurses and two are fully competent interRAI assessors.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>There is a rationale covering all service provision provided at Taradale Masonic Home and Hospital for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week. The clinical manager and clinical coordinator adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is provided with four experienced registered nurses providing this cover. Staff report that good access to advice is readily available when needed.</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>Residents and family reported there were adequate staff available to complete the work allocated to them. Residents and family interviews supported this. Observation of a six-week roster cycle confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. At least one staff member in each area has a current first aid certificate. There is twenty four hour/seven days a week (24/7) RN coverage in the hospital. There is a diversional therapist and an activities coordinator, and the activities programme is spread across all services. In addition, staff are employed for the kitchen, laundry, and cleaning services. Property management is managed by the property manager interviewed and staff are employed for both maintenance and grounds persons as required. Two support workers are employed, one 8.30am to 12.30pm and one 9am to 3pm daily to assist with bed making and support to the HCAs and this system works well. Staff are contracted such as the hairdresser, podiatrist, and physiotherapist. There is sufficient staff to cover the six ORA rooms which are currently unoccupied at the time of audit.</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>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on label as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. Clinical records were current and integrated with GP and allied health provider records. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on the site. This location has changed since the previous audit. Records are readily retrievable using an appropriate system. Residents' records are held for the required timeframes before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Current information about the facility and services offered is on Eldernet website which is updated daily during the working week and in the facilities information booklet. The entry criteria are documented and clearly communicated to the potential residents, their family/ whānau /the enduring power of attorney (EPOA), local communities and referring agencies. All residents who are in Taradale Masonic residential home and hospital have been assessed by the local needs' assessment service (NASC) as required by the organisational policy. All referrals are assessed by the clinical coordinator and the clinical team. Admission requests are prioritised according to level of need and probable admission date. Potential residents and family/ whānau are given a tour of the facility when requested prior to admission. The clinical coordinator has the overall responsibility for new admissions with the registered nurse (RN) on duty responsible for performing the admission process. The organisation seeks updated information from the NASC and general practitioners (GPs) for residents accessing respite care.</p> <p>The administration manager explains the admission process and agreement to the prospective residents and their family/ whānau as required and when the admission has been approved. The residents, family members</p>

		and EPOA interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files sampled contained completed demographic data, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements and are documented in the admission agreement.
<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>	FA	<p>The RNs and the clinical coordinator are responsible for managing the exit, discharge, or transfer in a planned and co-ordinated manner, with an escort provided as appropriate. The service uses the DHB's transfer form to facilitate transfer of residents to acute care services. Communication between services was documented in the progress notes reviewed for a resident who was transferred from another facility and for residents who were transferred to acute services. At the time of transition between services, appropriate information was provided for the ongoing management of the resident. An example of a resident recently transferred to the local acute care facility showed appropriate documents were provided to allow continuity of care for resident. Family of the resident recently transferred to acute services reported being kept well informed during the transfer of their relative.</p> <p>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/EPOA. Examples of this occurring were discussed. There is a clause in the admission agreement related to when a resident's placement can be terminated.</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>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and legislative requirements</p> <p>A safe system for medicine management using an electronic system was observed on the days of audit. The electronic system is accessed using individual passwords. Two RNs were observed administering medication following appropriate procedures and medicine management guidelines. They 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 and had a current medication administration competency. HCAs have advanced medicine management competencies to administer medication under the direction of RNs as second checkers for controlled drugs and some HCAs have basic medication administration competency to administer ointments only. A current copy of all staff who are competent to administer medicines and the level of competency is maintained and is accessible to all staff.</p> <p>The electronic prescription charts included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for 'as required' (PRN) medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine chart. Current residents' photos were</p>

		<p>uploaded, and allergies were documented where applicable.</p> <p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication was stored safely in locked cupboards and medicine trolleys in the nurses' stations. Medication reconciliation is conducted by RNs when resident is transferred back to service. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A pharmacist delivers the controlled drugs and unwanted medicine is collected at the time of delivery.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There was no food stored in the medicine fridge. There were no vaccines kept on site.</p> <p>There were no residents who were self-administering medications at the time of audit. Policies and procedures for self-medication administration were available to guide staff when required.</p> <p>The clinical coordinator reported that a comprehensive analysis of any medication errors will be completed as required as guided by the medication management policy. No medication error records sighted on the days of the audit. Staff receive regular education on medication management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Residents' diet requirements are assessed by the RNs during the admission process. Residents' food preferences, food allergies and special diet requirements were documented. A copy of the diet requirements form is provided to the kitchen team. Copies were sighted in the kitchen folder. Special diet is accommodated in the daily meal plan. There is a four weekly menu cycle in use that was last reviewed by a qualified dietitian in May 2021. The service operates with a current food control plan that was issued in February 2021 by the local city council.</p> <p>Residents' weight is monitored and there was evidence that any concerns in weight were identified early and managed appropriately. Additional supplements were provided where required. The head cook orders the food, and a list of preferred food suppliers was maintained. Records of incoming goods were maintained. The cooks and the kitchen hands have completed the required food safety qualifications. The kitchen and pantry were clean, and no food was stored on the floor. Cleaning schedules were sighted and completed as required.</p> <p>Temperature checks of fridges, freezers, cooking and serving temperatures were maintained. All decanted or cooked food in the fridge was covered and labelled. Food was transported to the serving areas in the dining rooms using baine maries. In mealtimes observed on the audit days, residents were given adequate time to eat their meals in an unhurried fashion and residents were provided with the support they required to eat their meals. Additional foods and fluids are accessible throughout the day and night if required. The interviewed residents and</p>

		family/ whānau expressed satisfaction in meals provided. Residents are involved in evaluating meal services through satisfaction surveys and residents' meetings. The meal satisfaction survey completed in October 2020 confirmed that residents were satisfied with the meal services.
<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	The clinical coordinator and administration manager reported that 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 or family are supported to find the appropriate care required. Examples given for the decline were where a resident is requiring higher level of care either due to complexity of care or behaviours of concern that makes them not fit in with the other residents. The resident and where appropriate their family of choice/EPOA are informed of the reason for declining entry to services and a data base is kept along with the reasons for the decline for two years. There is an option for the prospective residents to be put on the waiting list until a vacancy is available if desired. The waiting list records were maintained.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The residents' needs are assessed on admission using the organisation's admission assessment and care plan tool within 24 hours of admission. Nursing admission assessments were sighted in the residents' files reviewed. All residents had current interRAI assessments. The residents' identified needs and interRAI assessment outcomes were documented and served as a basis for care planning. Residents and family/whānau confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The Care plans reviewed were individualised and 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 the reviewed care plans with appropriate interventions documented.</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 was documented and verbally passed on to relevant staff. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</p>
Standard 1.3.6: Service	FA	Residents receive adequate and appropriate services to meet their assessed needs and desired. The HCAs and the enrolled nurses (ENs) work under the direction of registered nurses. Residents who attend specialist

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>programmes outside the facility are supported to attend and required interventions were documented in the resident's records reviewed. Documentation, observations, and interviews confirmed that care provided to residents and consumers was consistent with their needs, goals, and the plan of care. The interviewed GP verified that medical input was sought in a timely manner, medical orders are followed, and care is implemented as prescribed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs with appropriate storage area in place.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are provided by a diversional therapist (DT) with relevant qualifications and a rehabilitation and activities coordinator who is a qualified non-practising occupational therapist assistant. The DT and the rehabilitation and activities coordinator are responsible for completing the activities programme. Daily activities were written on white boards around the facility. A monthly activities calendar is provided to individual residents. Copies of the weekly calendar and monthly activities calendar were sighted in the residents' rooms. The DT and the rehabilitation and activities coordinator completes the residents' activities needs assessment within three weeks of admission and develop the activities and social care plan for each resident.</p> <p>The activities and social care plans reviewed reflected residents' goals, ordinary patterns of life and included community activities. The activities are combined for rest home and hospital level residents (continuing care residents). Village residents are welcome to attend concerts held in the facility. There are two HCAs who are allocated to provide individual activities to residents in the continuing care wing for one hour for five days a week.</p> <p>Individual, group activities and regular events are offered. The activities on the planner include quizzes, crosswords, concerts, churches services, exercises, slide show lectures, happy hour, and shop on premises. Individual activities include manicure, hand massages and Catholic communion. Three monthly residents' meetings are held and a monthly newsletter with input from the multidisciplinary team is completed. All residents in residential care and village residents receive a copy of the newsletter. Copies of the newsletters in large print were posted on the notice boards around the facility. Residents interviewed confirmed they find the programme satisfactory. Daily activities attendance records were maintained. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>The HCAs document care provided on each shift. The RNs document in the progress notes daily for residents receiving continuing care and weekly for residents receiving rest home level care. More frequent documentation is completed for any health concerns identified. The reviewed residents' notes evidenced that changes noted were reported to the RN.</p> <p>Formal care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, the service responded by initiating</p>

timely manner.		changes to the care plan. The short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. When acute conditions resolved, the short-term care plans were signed off. The residents and family/whānau interviewed confirmed their 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	Referrals to other health and disability services were sighted in the residents' records reviewed. Examples of referral sighted were to eye specialists, wound nurse specialist, diabetes mellitus and renal specialist. Support to access or seek referral to other health and/or disability service providers is provided with an escort provided if required. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. The family/whānau are kept informed of the referral process, as verified by documentation and interviews. The GP, residents' family/whānau and staff confirmed that any acute/urgent referrals were attended to immediately. Examples of residents sent to accident and emergency in an ambulance in emergency situations were sighted.
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, infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored, and staff interviewed knew what to do should there be a chemical spill/event. The property and maintenance manager interviewed stated that there was a main chemical storeroom available for all bulk supplies. Material data sheets were available for all chemicals in use. Groundsmen have their own lockup sheds for their tools and equipment required. There is adequate provision and availability of protective clothing and equipment, and staff were observed using this during the audit. Supplies are accessible to all staff working in all services.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible	FA	A current building warrant of fitness (BWOFF) expiry 1 November 2021 is publicly displayed. All buildings, plant and equipment comply with legislative requirements. Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose and are maintained. The property and maintenance manager who reports to the general manager was interviewed. The maintenance team covers two sites and the village. Planned maintenance is ongoing at all sites

<p>physical environment and facilities that are fit for their purpose.</p>		<p>including here at Taradale Masonic Home and Hospital. The testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in the documentation provided and reviewed, interviews with the property and maintenance manager and observation of the environment. An inventory and site history of all electrical equipment is maintained. Daily maintenance to be completed is signed off and dated when completed. All hoists both standing and transfer are checked annually last on the 14 July 2021 and records were reviewed. The environment was hazard free, residents were safe, and independence is promoted.</p> <p>External areas are also safely maintained and appropriate to the resident groups and setting. There is a large courtyard in the centre of the facility and several smaller courtyards between the wings. All garden settings are accessible as the home is on one level. A significant number of rooms open out to the garden areas. A variety of seating is available. Small areas of the main lounge are sunrooms and provide a warm area for the residents to sit during the day and to enjoy the garden views. The YPD residents have adequate space to walk around as needed and if any equipment is required this is accessible.</p> <p>Residents and staff confirmed they knew the processes to follow if any repairs or maintenance were required, that any requests are appropriately actioned and that they are happy with the environment. Families interviewed confirmed residents use all areas of the facility available and accessible to them.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are a variety of toilet/shower facilities within the facility in the rest home and the hospital areas. In the rest home communal showers are available in close proximity to the resident's rooms. Some rooms though have a toilet and vanity. All rooms have a hand basin in the room. Only a few rooms have a full ensuite e.g., shower, toilet, and hand basin. One relatively new wing of four rooms (RH) has two rooms that share a bathroom, shower, and hand basin but a separate toilet. No room has its own toilet and hand basin, and one room has a full ensuite bathroom. There is one additional shower in this wing close to the resident's rooms.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote resident independence. There are separate staff and visitor toilets available in the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move freely if able around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with photographs, furnishings, furniture, and other personal items being displayed.</p> <p>There is room available to store mobility aids, wheelchairs and mobility scooters if needed. Mobility aids are</p>

<p>provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>available as needed for individual residents in the other services to ensure independence and mobility. Staff, residents, and family reported the adequacy of the bedrooms and space provided.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available in all service areas for residents to engage in activities. The large lounges are used for recreational purposes, entertainment, and relaxation. The seating provided is comfortable and appropriate for the elderly or disabled. There is a separate family/whanau room near the hospital wing which is set up with a kitchenette, fridge and a lounge suite being available to families grieving or needing a private area for discussions to occur.</p> <p>There are two recessed areas/sunroom off the main lounge seen to be well utilised by residents during the day. There is a large dining room with adequate seating arrangements. Tables are set up for two, four and eight places at the main meal times. Comfortable dining settings with comfortable seating are available. Rest home, village and more independent hospital level residents access this main dining room. There is a separate dining room in the hospital service area. The dining rooms can be used for private family functions by arrangement. There is a separate hair salon available which is used regularly by appointment.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There is a large functional laundry on site with designated staff. All laundry staff are well trained and when interviewed the laundry assistant demonstrated a sound knowledge of the laundry processes including dirty/clean flow and handling of any soiled linen. The laundry staff member interviewed has been in the role for one year and works three days a week. The staff member demonstrated a good understanding of the role and responsibilities in the laundry and the principles of infection prevention and control. The other four days are covered by another experienced staff member. There are commercial washing machines and driers installed which are electronically monitored. Residents and family interviewed reported the laundry is managed well and clothes are returned in a timely manner.</p> <p>The cleaning and laundry staff have completed relevant training for their respective roles and for handling any chemicals required. The staff interviewed felt well supported in their roles. The chemicals are managed by the contracted service provider who checks the supplies and effectiveness of products used. The temperatures and machinery are also checked on a regular basis. All sluice rooms, cleaner's rooms and the laundry are locked (keypad access only) when not in use. The cleaning trollies are stored in the locked room when not in use. Filling stations are wall mounted in both the cleaners' rooms. Material data sheets are readily accessible. Chemical spills kits are available in both the cleaner's rooms if needed. Hand sanitizing zones are set up all around the facility for staff to access. Two cleaners are available for both the rest home and the hospital areas daily, seven days a week.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies, procedures and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster, local council, and civil defence planning guides and directs the facility in their preparation for any disasters and described the procedures to be followed in the event of a fire or other emergency. This was clearly apparent in a recent serious emergency situation which required a full evacuation of a wing on the 12 July 2021. A section 31 Notice was completed and HealthCERT and the DHB were notified. The action taken and managed by staff was worthy of a continuous quality improvement as per (1.4.7.3).</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 4 November 2019. The evacuation plan considers residents with special needs and physical disabilities. The home is divided into five fire zones clearly marked up around the total facility. A trial evacuation takes place every six months with a copy sent to the New Zealand Fire Service, the most recent drill being 1 April 2021 followed by the emergency situation 14 July 2021 which involved all staff on duty and staff off duty were called into the facility to assist with the evacuation required. The orientation programme for all new staff includes fire and security training. Staff confirmed their awareness of the emergency procedures and when interviewed highlighted the recent emergency situation and how this was effectively managed.</p> <p>Adequate supplies for use in the event of a civil defence emergency or other emergency including food, water, blankets, mobile phones, and a gas BBQ were available to meet the requirements for the 67 residents and up to 74 maximum if fully occupied. There is a generator onsite which was being serviced on the day of the audit. Emergency lighting is readily available and is tested regularly. Emergency water supplies with 15,000 litres being refreshed constantly. The tanks are fully drained six monthly next due October 2021. The water storage recommendations for Hawkes Bay/Napier local council is met. A check list of all supplies on hand is available and checks occur as per the internal audit schedule reviewed.</p> <p>Call bells alert staff to residents requiring assistance. There is a plan in place to review and replace the current call bell system which is monitored regularly.</p> <p>The training programme includes annual training on security, health and safety and emergency management. Staff check the facility between shifts. Doors are activated with card swipe access only. Cameras for security purposes are now installed and signage is available around the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors open to the outside gardens. Heating is provided in a variety of ways such as the new service areas including the main dining room, kitchen and hospital wing have underfloor heating. In the older part of the building the main lounge and the individual rest home rooms are heated with radiator heaters. The temperature is maintained at a comfortable temperature throughout all services. Residents and</p>

<p>natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>families confirmed this when interviewed.</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>	<p>FA</p>	<p>Taradale Masonic Home and Hospital has implemented 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 an external infection control specialist. Infection control advice is sought from the local DHB and public health when required. The infection control programme is reviewed annually and was last reviewed in January 2021.</p> <p>The clinical coordinator is the designated infection control coordinator. The responsibility of the ICC is documented in the infection prevention and control policy. Infection prevention and control matters are discussed in the quality review and staff meetings. The quality and education coordinator presents a report to the board monthly and infection prevention and control is part of the agenda. Reports to the boards were sighted.</p> <p>There was signage at the main entrance to the facility requesting anyone who has flu like symptoms or has been unwell with an infectious condition, 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 sickness screening is conducted, and records maintained as required. Staff interviewed understood these responsibilities. Current COVID-19 pandemic information from MOH website and pandemic plan was sighted in the COVID-19 pandemic folder.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC has completed the infection prevention and control training as verified in training records sighted. Additional support and information are accessed from the infection control team at the local DHB, the laboratory, the GPs and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>Personal protective equipment, hand sanitisers and adequate hand hygiene facilities around the facility were sighted on the days of the audit. There is an outbreak room set aside with outbreak management resources.</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>	<p>FA</p>	<p>The infection prevention and control policy folders are kept in the nurses' stations for both units and were accessible to all staff. The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed in May 2020 and included appropriate referencing.</p> <p>Staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. There are processes in place to isolate infectious residents when required. 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>	<p>FA</p>	<p>The quality and education coordinator provides ongoing education to staff. Infection prevention and control education is completed as part of the mandatory study days. Interviews, observation, and documentation verified staff had received education on infection prevention and control at orientation and ongoing education sessions yearly and per rising need for example, additional infection control education was provided during the COVID-19 pandemic lockdown period. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. Education attendance records were maintained.</p> <p>Education with residents is on an individual basis and has included reminders about handwashing and advice about remaining in their room if they are unwell. Residents' meeting minutes confirmed discussion of infection control measures in residents' meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities. The infections being monitored include infection of the urinary tract, wounds, eye, gastro-intestinal, influenza like illness, skin, multi-resistant organism, the upper and lower respiratory tract. All infections are recorded on a monthly resident infection monitoring and data collection form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.</p> <p>Monthly surveillance data is collated and analysed by the quality and education coordinator and ICC to identify</p>

<p>been specified in the infection control programme.</p>		<p>any trends, possible causative factors and required actions. Comparisons against previous months is conducted. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p> <p>There was no infection outbreak reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Taradale Masonic Home and Hospital actively works to minimise restraint use. Restraint use reduced by one in the past month. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints. The restraint coordinator provides support and oversight for restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>The restraint types in use on the days of the audit were one chair support brief and eleven bedrails. No residents were using enablers. These were approved as a last resort as all other alternatives had been trialed. This was confirmed in the quality review team meeting minutes, resident's records reviewed and from interviews with staff. The services' policy supports the use of the least restrictive type of restraint to maintain the resident's safety. The policy clearly stated that use of enablers will be voluntary, and the least restrictive option will be used to meet the resident's needs and promote independence. The interviewed staff understood the difference between an enabler and a restraint.</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 approval group consists of the clinical coordinator who is the restraint coordinator, the clinical manager, and the RN in consultation with the GP and is responsible for the approval of the use of restraints and the restraint processes. There restraint principles in place meets the legislative requirements and relevant professional codes of conduct to ensure residents' rights are protected. The clinical coordinator is the nominated restraint coordinator. The restraint coordinator approves all restraint following discussion with the resident's family, the GP and quality committee.</p> <p>The responsibility for restraint process and approval is clearly documented and lines of accountability clearly defined in the restraint minimisation and safe practice policy. The restraint in use was approved, and the overall use of restraints was being monitored and analysed. The signed restraint use consent forms were sighted in residents' files reviewed, where applicable. Evidence of EPOA and family/whanau involvement in the decision making was on file. Use of a restraint was documented in the care plans reviewed, where applicable.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The use of restraint assessment is completed by the restraint coordinator or the registered nurse when the restraint coordinator is not available. The resident's GP is consulted before use of restraint. Risk assessment is completed as part of the assessment process. Previous history of restraint use, underlying cause, existing advance directives, how future triggers or crisis will be managed, and cultural needs of the resident are considered. Initial assessment occurs at the time restraint use is required and ongoing assessment is completed three monthly and when there is a change in resident's physical or psychological health. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised, and the restraint coordinator described how alternatives to restraint are discussed with staff and family members, for example use of low beds, use of sensor mats and regular visual checks of residents. The restraint coordinator and the staff reported that restraint is used as a last resort option for resident's safety. Other interventions and alternatives such as de-escalation techniques are trialled first before restraint is utilised.</p> <p>Records sampled confirmed that frequent monitoring was completed to ensure the residents remained safe while using restraint. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes to ensure dignity and privacy are respected. The interviewed resident reported being monitored regularly when restraint is in use and confirmed that bedrail protectors were used as required. The bedrail covers were observed in place for residents who were using bedrails as restraint.</p> <p>There is a current restraint register that was updated every month and reviewed at each quality team meeting occurring monthly. The register was reviewed with all residents using restraints documented with enough information to provide an auditable record.</p> <p>Staff have received training on the restraint policy and procedure at orientation and annually as part of the mandatory training, together with challenging behaviour management and de-escalation techniques. Staff interviewed understood that the use of restraint was to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of the residents' files showed that the use of restraint was reviewed and evaluated during care plan and interRAI reviews. Three monthly restraint use reviews were completed consistently. Reviewed residents' records confirmed EPOA and family/whanau involvement in the evaluation process. The evaluation covers all requirements of the Standard, including the impact and outcomes achieved, and documentation completed as required.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a three-monthly review of all restraint use which includes all the requirements of this Standard. Monthly quality meetings with restraint on the agenda are completed. Individual use of restraint use was reported in the quality and staff meetings. Minutes of meetings sampled confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint education and feedback from staff and families. Records reviewed, minutes and interviews with the restraint coordinator confirmed that the use of restraint has been reduced over the past month with one resident no longer using restraint. Increased resident's monitoring and ongoing evaluation of behaviour and care provided was evidenced in the resident's records.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored,</p>	CI	<p>As part of the environmental checks, it was discovered that significant hazards were observed in three separate shower rooms all in close proximity to one another. All floor areas were found to be spongy in appearance due to water retention, there was obviously poor drainage of water when the showers were in use. The vinyl floor coverings were no longer sealed and were pulling away from the edges or covings. The associated risk was water collecting under the shower flooring increasing the damage to the floor areas and this also was a potential risk of tripping and there was an infection prevention and control issue. There was likelihood of injury or harm and the consequence of injury or harm to health was rated as a moderate risk which would end with first aid/medical treatment being required if an injury was sustained by a resident. The risk rating was</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate that the clinical manager acted upon a hazard and risk identification form stating that a significant hazard had been identified in a block of three showers. Action was taken immediately to lower the risk for residents accessing these three showers in relation to health and safety and also so as not to pose any risks to residents from an infection control perspective. The aim was to eliminate the identified hazard and high-risk status at the time. The plans presented to the board of trustees were authorised and all three bathrooms were totally upgraded. Residents and staff were pleased with the upgraded showers and the improved resources and equipment installed. Safety is promoted at all times and with the elimination of any risks, the staff and residents felt that safety was no longer compromised. Ongoing evaluations have led to other shower units being upgraded for safety and infection control purposes throughout the home as part of this quality improvement</p>

<p>analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>rated high on the risk rating table documented. The discussion with management and staff was to establish an action plan, review the hazard and complete a risk analysis within 48hours. It was decided to eliminate the hazard raised by collating a report and presenting this to the board of trustees with plans for an upgrade and an estimated cost factor was therefore incorporated into the report. A report was presented to the Board of Trustees and the plans were approved and a date to commence the upgrade was established.</p>	<p>outcome.</p>
<p>Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>CI</p>	<p>On the evening of 12 July 2021 at 5pm a contracted trade person/plumber was working in the roof above a wing that accommodates eight residents one of whom was in the DHB. A water leak was identified, and the staff were advised to ring the fire service as the leak was from the fire sprinkler system and this would need to be located and turned off by the fire service only. The fire alarm activated immediately, and staff came to the check the wing. Fortunately, all residents were accounted for and were present in the dining room at this time. Just as a staff member had checked the immediate area and fire zones were closed off the ceiling collapsed. The management team were contacted, extra staff to manage and organize the relocation of the residents was organised immediately and eight resident's family members were contacted and informed of the situation. A full debrief occurred the next day and a plan moving forward was arranged. Family and</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate that a recent serious emergency situation was managed effectively and efficiently to ensure safety for residents and staff and that all staff involved contributed and went over and above their working shifts and off duty time to ensure the residents were not compromised in any way during this adverse event. The organisation has well developed systems and processes for fire and emergency situations. Staff have received appropriate training, and this was evidenced at the time of this event occurring and in the incident management form completed. Prompt action by staff in contacting the fire service, and checking the immediate area and zones was facilitated. The service responded to emergency response in a timely manner and all relevant management, maintenance and additional staff were contacted by staff and the clinical manager. Seven residents were safely relocated to the main lounge areas and staff monitored them throughout the duration of the evacuation. The affected area was cordoned off and designated a construction area. Additional staff cared for residents overnight in the lounges with no issues being highlighted. Residents were</p>

		<p>residents were updated. Throughout this incident resident and staff safety was paramount.</p>	<p>safely relocated to safe areas of the home (some to their own rooms) the next afternoon. Acknowledgement was provided by residents, families, and the fire service on how this serious incident was effectively managed. The fire sprinkler remained non-operational and additional staff were rostered over the total time for repairs to be completed. A review and evaluation of this serious event occurred, and some additional resources were added to the emergency equipment should the circumstances require them next time.</p>
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End of the report.