

# Masonic Care Limited - Horowhenua Masonic Village

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Masonic Care Limited
<b>Premises audited:</b>	Horowhenua Masonic Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 3 August 2021 End date: 4 August 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	68

# Executive summary of the audit

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## 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

Horowhenua Masonic Village provides residential services at rest home and hospital level for up to 77 residents. The facility is operated by Masonic Care Limited and is managed by a village manager and a clinical nurse manager.

Residents and families reported high satisfaction with the care provided.

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

A new position of director of nursing quality and risk and a clinical governance committee have been established since the previous audit.

An electronic client management system is currently being trialled within the group and is to be implemented in Horowhenua Masonic Village in February 2022.

A continuous improvement rating has been awarded for a reduction in residents' falls. There are no areas for improvement identified from this audit.

## Consumer rights

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

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

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Horowhenua Masonic Village when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

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

Care for any 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 understood and implemented related policies. Professional boundaries are maintained.

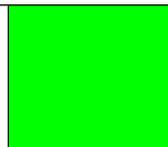
Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Horowhenua Masonic Village has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaints investigated by external agencies since the previous audit.

## 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.

Masonic Care Limited is the governing body and is responsible for the services provided. A strategic business plan includes a purpose, vision, values and goals. Quality and risk management systems are fully implemented at Horowhenua Masonic Village and documented systems are in place for monitoring the services provided, including regular reporting by the village manager to the director of nursing who reports to the governing body.

The facility is managed by an experienced and suitably qualified manager. The village manager is supported by a clinical nurse manager who is a registered nurse and the director of nursing. The clinical nurse manager is supported by three charge nurses and is responsible for oversight of the clinical services.

There is an internal audit programme in place. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, health and safety, management, various staff and residents' meetings are held on a regular basis.

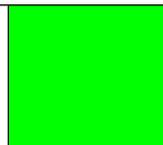
Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place and followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are always rostered on duty. The clinical nurse manager and charge nurses are rostered on call after hours.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with liaison evident between Support Links and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in each of the three units.

The planned activity programme is delivered by four part time diversional therapists. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

There is a mix of rooms with individual and shared full ensuites. Adequate numbers of additional bathrooms and toilets are available. Several lounges, dining areas and alcoves are available. Shaded, external areas and sitting are provided.

An appropriate call bell system is available, and residents reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures and emergency resources are readily available. Emergency supplies are checked regularly. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Personal and small items are laundered on site and linen by an external company. Cleaning and laundry processes are evaluated for effectiveness.

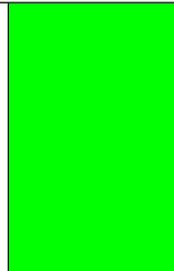
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraints and enablers at the time of audit. Restraint processes are in place and meet the standards.

## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	1	100	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>Horowhenua Masonic Village has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all new staff employed and is part of the ongoing yearly training programme, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed gaining consent for day-to-day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. There is an independent facility advocate who comes in once a month and chairs the residents' meetings, types up and distributes the minutes and reports back to management. Staff are also aware of how to access the Advocacy Service if this is required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment. The facility encourages visits from family and friends, family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. There is a family/whānau room available and several lounges throughout. Family can stay if there is a spare room so they can support their relative should they be receiving palliative care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.</p> <p>One complaint has been received since the previous audit and this have been entered into the complaint register. Complaint documentation was reviewed and actions taken were recorded and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The village manager is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A section 31 notice was sent to HealthCERT as a result of the complaint.</p> <p>There have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>When interviewed, the residents and family/whānau of Horowhenua Masonic Village reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and Māori throughout the facility and each resident has a copy of this in the information folder in their rooms. Information on how to make a complaint and provide feedback is</p>

		available in each of the three units.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and their families confirmed that services are provided 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 resident information is held securely and privately, when exchanging verbal information and during discussion with families and the GP. All residents have a private room. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and quite often the community activity comes to them. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs have been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were two residents at Horowhenua Masonic Village that identified as Māori. Staff support residents who identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau. There is a current Māori health plan and a Māori health group which meet bi-monthly; minutes were reviewed during the audit. Residents are encouraged to access the marae and local kaumatua. Guidance on tikanga best practice is available and there are staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	FA	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. There are a number of staff who can act as interpreters otherwise they would access an external service. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		survey confirmed that the resident's individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The facility general practitioner also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. There is an independent care facility advocate who visits once a month, and if required is able to read the residents' survey to them so it remains totally independent.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	A quality project has been undertaken that has significantly reduced the rate of falls in unit 3. This has been awarded a continuous improvement rating.  The service provides and encourages good practice through evidence-based policies, input from external specialist services and allied health professionals, for example hospice, wound care specialists, dieticians, podiatrist and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported that they receive management support for external education and access their own professional networks. There are currently 11 staff completing an HCL computing course which runs for twenty weeks. Ongoing yearly training for RNs and care staff is provided in house, with education provided by the Parkinson's nurse and Hospice with staff on the waiting lists for palliative care and pressure injury education.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access an interpreter service and there are also members of staff who are bilingual. A resident with English as a second language has family members to assist if required,

		they are also able to understand English.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Masonic Care Limited is governed by a trust board that is responsible for setting the strategic direction and the service. The strategic business plan 2016-2021, which is currently under review, includes a purpose, vision and values. There are four goals: to be sustainable; to provide consumer centred care; to achieve on-going quality improvements and to be the best place to work. The service philosophy is in an understandable form and is available to residents and their family / representative, or other services involved in referring clients to the service.</p> <p>The chief executive (CE) stated that for Masonic Care to move forward the Board recognised the need to involve all staff within the organisation at the different levels concerning the strategic goals. With this in mind, a director of nursing quality and risk (DON) role has been established and a clinical governance committee has recently been formed. The first meeting was held on the 3 June 2021. The purpose of this group is to ensure Masonic Care Ltd is accountable for continuously improving the quality of the care provided and safeguarding high standards of care by creating an environment of excellence. The clinical governance committee is also charged with providing strategic direction and clinical leadership by making recommendations to the Board of Masonic Care Ltd. The four strategic goals are continuously measured and reported on by the clinical governance group, including reporting back to all the facilities within the group.</p> <p>The village manager (VM) has frequent contact with the DON and clinical reports are provided to the DON who in turn reports to the CE and the Board. Information, including quality data is accessed via the electronic system. The DON and CE reported they work closely and discuss all activities concerning the facility.</p> <p>The senior management team meet weekly with the VM and set the weeks activities for the facility.</p> <p>The facility is managed by an experienced village manager who has been in the position for 12 years. The village manager has a background in physiotherapy and is supported by a clinical nurse manager (CNM) who is an experienced RN and has been in the role for 11 months. The CNM prior to this role was one of the charge nurses working in the facility. The CNM is responsible for oversight of the clinical services.</p> <p>Review of the managers' personal files and interview of the VM and CNM evidenced they have undertaken on-going education in relevant areas including attending conferences and forums.</p> <p>Horowhenua Masonic Village is certified to provide hospital level and rest home level care with 14 bedrooms and the nine care suites approved as dual-purpose.</p> <p>The service provider has contracts with the DHB for aged related residential care services (68</p>

		residents - 36 rest home, including five Occupation Right Agreements (ORAs) and 25 hospital level care, including three ORAs), and complementary care services (three rest home and one hospital level). Contracts are also held with the MoH for three YPDs under the age of 65 years (one hospital and two rest home level).
<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	If the village manager is absent, the clinical nurse manager, operations manager and administrator will cover. During the absence of the CNM, the charge nurses will cover the clinical services with support from the DON and the quality manager.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality management framework including dimensions of quality, objectives, quality improvements and quality assurance guides the quality programme. The quality improvement register is current. Quality initiatives continue to be developed and implemented following trends being identified. (Link to 1.1.8.1)</p> <p>Quality data is collected, collated and comprehensively analysed, including audits, incidents/accidents, surveys and clinical indicators and this is entered into an electronic programme provided by an external company. The programme produces graphs, reports and benchmarking with other like facilities. Quality/infection prevention and control, registered nurse/restraint, staff, health and safety, and residents' meetings are held regularly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this. A monthly newsletter is produced by the quality team that has good information for staff and is discussed at the quality and RN meetings.</p> <p>Resident/family satisfaction surveys for 2021 have been collated and corrective actions have been developed and implemented. Review of results evidenced a high rate of satisfaction with the service.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies have been allocated a risk rating and are reviewed from one to four years based on the rating. Policies / procedures have been reviewed and are current. Obsolete policies are archived in the electronic system. Staff are notified via the quality newsletter of reviewed and updated/new policies. Discussion is held at various meetings and staff access the policies electronically. Staff confirmed they are advised of updated</p>

		<p>policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan includes a matrix and hazard/risk register that is comprehensive and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate each hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes. Minutes of the health and safety meetings evidenced a different topic is promoted by staff each month (e.g., slips, trips and falls).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. These are reviewed by the RNs on duty who either investigate and signs off as closed, or if required, escalate to the CNM and quality coordinator. The CNM is responsible for managing these, and if serious or critical, the village manager and CE are advised. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. The quality coordinator is responsible for entering all incident/accidents into the register.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The VM reported there have been 13 section 31 notifications to HealthCERT since the previous audit consisting of 12 pressure injuries, five of which were acquired externally. The thirteenth was the notification following a complaint. The VM advised the employment of a new CNM since the previous audit, has been notified to HealthCERT.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files reviewed included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The orientation programme is robust and includes a comprehensive orientation book for both nonclinical and clinical staff with competencies. All new staff are required to complete this. The workbook is completed within six weeks to three months of employment. Staff performance is</p>

		<p>reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>In-service education is provided for staff using several ways including half day study days repeated three times during the month of October, 'toolbox talks' at handover, specific topics relating to residents' health status and staff meetings. The local DHB and hospice also provide an education programme for RNs and staff attend other external education. Individual records of education are held electronically. Competencies were current including medication management and restraint. Attendance records are maintained. Of the 13 RNs, six are interRAI trained and have current competencies. All RNs, some care staff and others including the activities staff and maintenance staff have current first aid certificates.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete, and they are encouraged to do so. Two staff members are Careerforce assessors. Nine care staff have attained level two, 21 have attained level three and 19 have attained level four.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The rosters evidenced staffing levels exceed the minimum requirements. The CNM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered. The VM, CNM and charge nurses work full time. The three units have individual rosters. Each unit has an RN rostered on duty on the morning (charge nurse). In the afternoon shifts two to three RNs work facility wide, and one RN is based in unit one on the night shift. The CNM and charge nurses are rostered on-call after hours.</p> <p>Of the 13 RNs, one is a new graduate with the rest of the RNs ranging from two years to 10 years' experience working in aged care. Fifty-one health care assistants are employed to cover the three shifts and additional hours are available if the acuity levels of residents increase. The rostering includes the ORA care suites which are included within the facility footprint.</p> <p>Most of the laundry is managed by an external contractor and care staff are responsible for managing small items and residents' personal clothes. Four activities coordinators are employed (two are currently completing the diversional therapy course). Five staff members are responsible</p>

		<p>for maintaining the environment including the lawns and gardens.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they are happy with the staffing levels and there are enough staff on duty that provides them or their relative with a high standard of care. Observations during the audit confirmed good staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely in the administration block on site and are readily retrievable. Resident's records are held for the required period of time before being destroyed. No personal or private resident information was on 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>	FA	<p>Residents are admitted to Horowhenua Masonic Village following assessment from the local Support Links Service, as requiring the level of care that Horowhenua Masonic Village provides. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process.</p> <p>All residents prior to admission have a COVID-19 screen and the facility are guided by MOH guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the MidCentral District Health Boards 'Pink envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing</p>

		management of the resident. All referrals are documented in the progress notes.
<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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN on night shift signs in the medications against the prescription, then signs and dates each blister pack. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are 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. Controlled drugs are signed in and a pharmacy check is carried out every six months and this was evidenced in the controlled drugs register.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room did not have temperature records taken at the time of the audit.</p> <p>Good prescribing practices were noted, these included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are as per the policy and any verbal orders are rare and must be given to the RN, then prescribed in medimap before being administered. Facility GP's have remote access to medimap. The documentation is then signed and scanned into the electronic patient notes.</p> <p>Vaccines are not stored on site. Pharmacy gives the required COVID-19 vaccines, and as of the 24 June, 68% of staff are vaccinated and 83% of residents with the exception of those who did not want to be vaccinated.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The food service is provided on site with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>reviewed by a qualified dietician on the 9 May 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary industries on the 17 March 2020, for 2 years with a grading certificate 'A'. At time of audit, the kitchen was observed to be clean and the cleaning schedule was maintained.</p> <p>Food temperatures, including for high-risk items, are monitored and recorded as part of the plan using a paper base recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from Support Links, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral for reassessment is made to Support Links and a new placement is found in consultation with the resident and the whanau/family. Examples of this occurring were discussed with the clinical manager.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>On admission, residents of Horowhenua Masonic Village are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, activities, physiotherapy, dietitian, to identify any deficits and to inform initial care planning. Within</p>

<p>gathered and recorded in a timely manner.</p>		<p>three weeks of admission, residents (except for respite, ACC and YPD residents) are accessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>Those long-term residents not being assessed using the interRAI assessment tool have clinical assessments to inform care planning, these are reviewed every six months or if the resident's needs change.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.</p> <p>All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at Horowhenua Masonic Village are paper based. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>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/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs.</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>The activities programme is provided by four part time activities co-ordinators who support the residents Monday to Friday 9.00am till 5.00 pm and on Saturday 9.00 am until 3.00 pm. Two of the co-ordinators are currently training and the activities co-ordinator who oversees the programme in conjunction with the clinical nurse manager and village manager opted not to do the training.</p> <p>An activities assessment is completed and a cultural history undertaken on admission to ascertain the resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated daily and documented once a week and as part of a six monthly multidisciplinary care plan review. There are two residents who identify as Māori and they are greeted in their native tongue and support is given to anything culturally appropriate for them. They celebrate Matariki and are currently preparing for Māori language week.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'housie', knitting and visiting entertainers. There are individual and group activities offered and a regular weekly van outing. There are gender specific activities for female and male residents. Hospital residents have a separate activity programme. There are several lounge areas and an activities room as well as the individual's bedrooms where they have the opportunity to watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families have the opportunity to evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the annual resident satisfaction survey. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in</p>

		evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has two main medical providers, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files, including to the tissue viability nurse. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register is current.</p> <p>Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A building warrant of fitness is displayed at the front entrance that expires on the 1 June 2022. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways are wide enough and there is room for residents to pass comfortably in all areas.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by a team of maintenance staff who demonstrated good knowledge. The testing and tagging of electrical equipment and calibration of bio-medical equipment were current. Hot water temperatures at resident outlets are maintained within the recommended range.</p> <p>There are external areas available that are appropriate to the resident groups and setting. Large external courtyards with seating and shade are available for residents to frequent. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before</p>

		use and they are competent to use it.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. There is a mix of full ensuites and those with a wash hand basin and toilet. Two rooms do not have access to an ensuite; however, these rooms share a bathroom next to the rooms.</p> <p>Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is a mix of bedroom sizes with the care suites being spacious. Adequate personal space in bedrooms is available to allow residents and staff to safely move around in. Equipment was sighted in the rooms with sufficient space for both the equipment and at least two staff and the resident. The residents' rooms are personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own and stated their rooms are suitable for their needs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are numerous areas for residents to frequent. Good access is provided to the lounges and the dining room areas with residents observed moving freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas. Resident and families commented they can also go to the chapel if they feel like a quiet time.</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>	FA	<p>Cleaning and laundry policies and procedures are documented and guide services. The facility is cleaned to a high standard. There are processes in place for collection, transportation and delivery of linen and residents' personal clothing.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and visits from the chemical company representative. Reports from the chemical company representative and completed audits for laundry and cleaning were reviewed. Linen is laundered by an external contractor and care staff are responsible for residents personal washing and small</p>

		<p>general items.</p> <p>There are safe and secure storage areas and staff have appropriate and adequate access to these areas, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities and gel are available throughout the facility.</p> <p>Residents and families stated they were satisfied with the cleaning service.</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>	FA	<p>A letter from the New Zealand Fire Service (NZFS) dated 9 April 2013 approving the fire evacuation scheme was sighted. The last drill was undertaken on the 24 June 2021 and a copy sent to the NZFS. Emergency and security management education is provided at orientation and at the in-service education programme.</p> <p>Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements along with policy/procedures for visitor identification.</p> <p>Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment was accessible, current and stored appropriately.</p> <p>The service has a call bell system in place that is used by the residents, families and staff members to summon assistance. All residents have access to a call bell. Call bells are checked by the maintenance staff. Residents confirmed they have a call bell and staff respond to it in a timely manner.</p> <p>The service has documented processes for essential, emergency and security services. There is at least one designated staff member on each shift with appropriate first aid training. Staff records sampled evidenced current training regarding fire, emergency and security education.</p> <p>Information in relation to emergency and security situations is displayed and available for staff and residents with evidence of emergency lighting, torches, gas and BBQ for cooking and extra food supplies. Emergency water is maintained in three tanks combining the amount available to 3,800 litres. Battery powered emergency lights and a generator are also available.</p> <p>External doors are locked in the evening and alarmed. The building externally has CCTV cameras operating and an external contractor checks the property several times per night.</p>
Standard 1.4.8: Natural Light,	FA	The facility is heated by water filled heaters. There are also heat pumps in communal areas and

<p>Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>electric wall heaters in the bathrooms.</p> <p>Procedures are in place to ensure the service is responsive to residents' feedback regarding heating and ventilation in the facility. Residents and families confirmed the facility is maintained at an appropriate temperature.</p> <p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The facility is smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Horowhenua Masonic Village provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual with input from the infection control nurse and quality manager. The infection control programme and manual are reviewed annually.</p> <p>A unit charge nurse is the ICN with input from the quality manager and support of the CNM who was the previous ICN. Infection control matters, including surveillance results, are reported at bi-monthly meetings. The minutes are available for all staff to review. Infection control data is included in monthly data which is collated into a board report for the group. Results are shared with the RN's then made available in each of the units. Infection control statistics are entered into the quality management system and these are benchmarked.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they are unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN has the appropriate skills, knowledge and qualifications for the role and has been in the role for 20 months. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a COVID-19 management plan in place and new admissions that come from the hospital are self-isolated for three days and their observations taken for two weeks. Those who are admitted from home have their observations taken for two weeks. The plan details all the actions required by the service stream within the facility in response to each of the alert levels.</p> <p>The ICN and the quality manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing with a full review this year. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is analysed, and the results are shared with staff electronically and at RN and carer meetings and handovers. Data is benchmarked externally which provides assurance on the facility's infection rates and where they rate in the sector.</p> <p>A good supply of personal protective equipment is available and Horowhenua Masonic Village has processes in place to manage the risks imposed by COVID-19.</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>The restraint coordinator who is an RN stated Horowhenua Masonic Village is committed to reducing restraint use. Equipment used includes sensor mats and 'landing mats'. There were three residents using a restraint and three residents using an enabler during the audit.</p> <p>The definition of a restraint and an enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, as confirmed at staff and management interviews.</p> <p>Staff interviews and staff records evidenced restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation ongoing training is provided. Restraint training is included in the staff mandatory study days and staff competencies were current. The RN and quality meetings included restraint as a standard agenda item.</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>Restraint use is overseen by the restraint coordinator/RN and the responsibility for this position is defined in the position description.</p> <p>Restraints are authorised following a comprehensive assessment/check list of the resident. The approval includes consultation with other staff, such as the charge nurse, the GP and the resident's family. The restraint consent forms evidenced consent for restraint is obtained prior to using restraint.</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>Restraint assessments were completed and identified restraint related risks, underlying causes for behaviour that requires restraint, existing advance directives, past history of restraint use, history of abuse and or trauma the resident may have experienced, culturally safe practices, identification of desired outcomes and possible alternatives to restraint. There was evidence that all enabler and restraint use was initiated following completion of appropriate assessments.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>The restraint coordinator stated that restraints are used as a last resort after alternative interventions have been explored. The restraint register was current and meets the standard. Staff have current</p>

<p>Services use restraint safely</p>		<p>restraint competency assessments.</p> <p>Staff were aware of advocacy services and that support is available. The contact details for this service are documented and the service can be accessed when needed to inform residents and their families.</p> <p>Residents using restraint have a restraint care plan. Review of residents' files confirmed this. Documentation in the residents' files relating to risk around restraint is individualised and evidenced good detail.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint coordinator confirmed evaluations of the restraints are completed at three-monthly intervals in line with the GP reviews. Evaluation and review of restraints meet the standard. The restraint coordinator confirmed communication with families regarding restraint and enabler use and discussions are held around reducing or minimising any restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint monitoring and quality review of restraint use is managed through monthly reports provided and discussed at the RN and quality meetings. A restraint audit is completed six monthly and the coordinator writes a full report six monthly. Review of documentation including meeting minutes and interview of the restraint coordinator confirmed this.</p>

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The quality data report recorded the percentage of falls occurring in unit 3 accounted for between 59% and 72% of all falls occurring in the facility in a four-month period. The number of falls per month in unit 3 were between 18 and 28 for this period.</p> <p>A group was formed which included unit 3 health care assistants and RNs to raise awareness of the falls rate in unit 3, identify potential contributors to the high number of falls and identify actions to trial/implement. During the project the impact of the interventions was monitored and opportunities for practice changes that could be shared with other areas of the facility were identified.</p> <p>Residents at high risk of falling and interventions to try and reduce the number of falls were identified. Falls literature including from ACC, the Frailty Care Guidelines 2019 and an internet search were undertaken. The quality coordinator and clinical nurse manager reviewed the facility’s policies and falls related documents.</p> <p>Falls data was reviewed to look at the day of the week, time-of-day</p>	<p>A quality initiative was undertaken to reduce the number of residents’ falls in unit 3 following analysis of data. Meetings were held and a plan implemented with strategies to reduce the high falls rate. This has resulted in the falls rate reducing significantly and remains consistently low in line with the other two units.</p>

		<p>falls were occurring and associated activities prior to the falls occurring to see if patterns could be identified. 'Measles maps' were developed to track when falls occurred. They were colour coded to identify the shift that falls occurred on, to look for trends. The measles maps were displayed in the unit 3 office so staff could track their progress and see improvements.</p> <p>Pads were purchased to use on chairs to help prevent residents from slipping out. Strategies, such as intentional rounding, were discussed with staff and introduced.</p> <p>Incident and accident forms were reviewed and changes to the formatting agreed. A space was made on the incident and accident forms so that the RN reviewing the fall could document actions to help prevent another fall from occurring. Previously the forms recorded information about the fall but there was no evidence or focus on strategies to prevent further falls from occurring. The newly formatted form was then trailed by unit 3 staff.</p> <p>The group agreed to changes to the resident falls risk assessment and intervention plan documents. Unit 3 staff trialled the use of purple dots on the door of residents at high risk of falling. This strategy has been implemented across the facility. Graphs were provided to unit 3 staff regularly so they could assess progress. Registered nurses were updated on progress with the project at their meetings.</p> <p>Documentation reviewed evidenced the number of falls per month steadily reduced from 28 to 8 in the following six-month period. The number of falls in all units continues to be monitored and the percentage of falls in unit 3 continues to decrease and be consistent with the other two units.</p>	
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End of the report.