

Oceania Care Company Limited - St Johns Wood

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:

Legal entity:	Oceania Care Company Limited
Premises audited:	St Johns Wood
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 September 2021 End date: 28 September 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:	50

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
Yellow	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
Red	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

St Johns Wood Home and Village provides aged residential care for people who require hospital or rest home level of care. The service is operated by Oceania Healthcare Limited. Day to day management and all service delivery is overseen by a business and care manager (BCM). This role became vacant recently and was being filled by an acting BCM who has long term experience as a BCM with Oceania.

The BCM is supported by an RN clinical manager (CM) who manages the overall delivery of clinical care. Both the acting BCM and CM are suitably qualified and experienced as managers in aged care. They are directly supported by two Oceania executive leaders, a regional clinical manager (RCS) and regional operations manager. The regional clinical manager was on site during this audit.

There have been no changes to the size or scope of the services provided since the previous surveillance audit in 2019. Construction work was underway to convert up to ten more village apartments to care suites.

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 a pre audit review of policies and procedures, and onsite review of residents' and staff files, observations and interviews with residents, family members, management, staff, a contracted physiotherapist, a visiting community support provider, and a general practitioner (GP). Feedback from all interviewees was positive.

There were no areas identified as requiring improvement as a result of the audit. A rating of continuous improvement was awarded for achievements in reducing pressure injuries.

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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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, gender, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

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

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

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

A complaints register is maintained with 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.

The annual business and quality risk management plans include the scope, direction, goals, values and mission statement of the organisation. Experienced and suitably qualified people manage the services being delivered.

The quality and risk management system includes monitoring service delivery and other operations through internal audits. Quality improvement data is collected, analysed for trends and leads to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment, orientation and management of staff is based on good employment practices. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

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

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

Access to the facility is appropriate and efficiently managed with liaison evident between the Needs Assessment Service Co-ordinator 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 each of the shifts.

The planned activity programme is delivered by three part time activity staff. 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 and clean and meets food safety standards. Residents are surveyed on an annual basis regarding 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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The environment meets the needs of residents and all areas inspected were clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are maintained and safe and are accessible to all residents.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are managed safely.

Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised.

Residents reported a timely staff response to call bells.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were two residents using restraints at the time of audit and two residents using enablers.

Staff understood that the use of enablers is voluntary and only implemented at the individual's request and consent to use these.

A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes and are provided with regular education.

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.
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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.

Covid-19 related processes are in place to manage change in Ministry of Health Covid-19 response levels.

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	1	49	0	0	0	0	0
Criteria	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)
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>St Johns Wood 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). This is displayed throughout the facility in both English and Māori, residents receive a copy of this in the admission pack. 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 part of the ongoing "GEM" study days for all staff as was verified in training records. The Code is also covered by Age Concern when they come into the facility to see residents and staff.</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.</p> <p>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>

		Staff were observed gaining consent for day to day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, 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. During COVID-19 restrictions staff have encouraged residents to “zoom” with their relatives in an effort to enable them to engage in face to face conversation with their family/whānau.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they understood the process and would not hesitate to raise concerns if they had any. Residents said they were encouraged and supported to raise issues and concerns at their monthly meetings. There was evidence their feedback was taken into consideration and changes were made as a result.</p> <p>Oceania’s process for complaints management is that all complaints are notified to support office who allocate responsibility for management and investigation. According to their job description the BCM is responsible for complaints management and follow up with input from the clinical manager and other team members if necessary.</p> <p>The complaints register recorded three complaints received in this calendar year. Documents and interviews related to these confirmed that each complaint had been acknowledged in writing, investigated and resolution achieved with all parties. There have been no complaint investigations by the office of the Health and Disability Commissioner, or the district health board since the previous surveillance audit.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>When interviewed, the residents and family/whānau of St Johns Wood 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 at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available and displayed in the residents' lounge.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and 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 the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room and ensuite facilities. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas and a family whānau/garden lounge.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility and outside in the community. 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</p>	<p>FA</p>	<p>There are currently no residents at St Johns Wood that identify as Māori. Staff receive annual education to enable them to support residents who do 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 whānau. There is a current Māori health plan and guidance on tikanga best practice is available. There are staff who identify as Māori in the facility and who can act as a resource. Te Ara Whakapiri Principles and Guidance for the Last Days of Life is utilised, and staff spoken to were familiar with this.</p>

beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual.</p> <p>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. The residents' survey results evidenced that the residents' needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice. This is demonstrated in an initiative to provide a "dignified farewell" when a resident passes away. This is done with the family/whānau approval. St Johns Wood have gone beyond Te Ara Whakapiri, when the tupapaku leaves the property a guard of honour is formed with their favourite music playing.</p> <p>Good practice is also demonstrated through evidence based policies, input from external specialist services and allied health professionals, for example, the 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.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training for RNs and care staff is provided both in house (GEM) study days and from external providers.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>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 a timely manner about any incidents or</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access an interpreter should this be required and several staff are bi-lingual.</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 Oceania group develops an annual business plan with objectives and goals that each of its care facilities responds to. This is monitored for progress by the executive management team, from information provided by each of facilities monthly business status report on identified indicators. The organisation's mission statement, vision and values are displayed at the entrance to the facility.</p> <p>St Johns Wood is currently being managed by an acting Business Care Manager (BCM) who is supported by a Clinical Manager (CM). The previous BCM resigned a month prior to this audit and recruitment to replace this person is underway. The acting BCM has held roles within Oceania since 2006.</p> <p>The CM is experienced in aged care having worked as a clinical manager since 2009. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements.</p> <p>The BCM and CM confirmed knowledge of the sector, regulatory and reporting requirements and maintain their currency through attendance at conferences and study days. The management team is supported in their roles by the Oceania executive and the regional teams who maintain regular communication and monthly onsite assistance.</p> <p>The facility is certified to provide rest home and hospital level care. There are 61 dual purpose beds and one dedicated rest home bed, total 62 rooms. Of these rooms, 38 are designated care suites and are available under an occupation right agreement (ORA). The other 24 rooms are standard rooms. There were 50 residents on site at time of the audit. This comprised 32 rest home level care residents (one being short term/respite) and 18 requiring hospital level care (one under the age of 65 years).</p> <p>There is a stated maximum of 70 residents which allows for up to four couples to occupy care suites. The provider desires an increase in maximum resident numbers. A proposal to increase numbers should occur at a partial provisional audit after the current building conversion to more care suites is completed.</p>

		The service has contracts with the DHB for the provision of rest home and hospital level care; respite care, long term support – chronic health care (LTS-CHC), and palliative care.
<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>As per Oceania policy, the BCM delegates their management responsibilities to the CM with day to day support from the RCM during any temporary absence. Cover for the CM's absence is allocated to a senior RN under the BCM's supervision. As evidenced on site, a qualified and experienced relief manager from the Oceania group was acting in the BCM role until a new BCM commences employment.</p> <p>Staff stated that senior management absences are well managed.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>St Johns Wood follows the Oceania documented quality and risk management system which is well embedded in practice and reflects the principles of continuous quality improvement. The Oceania management group regularly reviews all its policies with input from relevant personnel. All policies were current at the time of this audit. Policies 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 currently known best practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Service delivery is monitored through complaints, internal audit activities, regular resident and relative satisfaction surveys and the organisation's reporting systems which utilise a number of clinical indicators such as incidents and accidents, surveillance of infections, pressure injuries, falls, and medication errors.</p> <p>Quality improvement data is collected, collated and analysed to identify trends. Where audits or quality data indicated the need for improvement, corrective action plans were developed, implemented, and evaluated before being closed out. There is communication with staff of any subsequent changes to procedures and practice through meetings and staff notices. A range of meeting minutes (quality/health and safety, RN, restraint, infection control and other staff meetings) confirmed how this information is reported and discussed with all levels of staff. Residents and family are notified of relevant updates via resident meetings or newsletters.</p> <p>Staff reported their involvement in quality and risk management activities through their participation on committees and with internal audits.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey results from August 2020 had a 44% return from respondents and revealed high satisfaction with</p>

		<p>services. This was also confirmed by the residents and family members interviewed.</p> <p>The organisation has a risk management programme implemented which records management of risks in clinical, environment, human resources and other areas specific to the facility. Health and safety policies and procedures are documented along with a hazard management programme. The hazard register sighted was current and is kept updated.</p> <p>Staff interviews confirmed an awareness of health and safety processes and the need to report hazards, accidents and incidents promptly. The BCM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and follows requirements. There have been no WorkSafe notifications since the previous audit.</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>Staff document adverse and near miss events on an accident/incident form. Interviews and a sample of incident forms selected for review showed the resident's family had been notified where appropriate, an assessment had been conducted and observations completed. All incident forms are reviewed and where necessary investigated by the CM. There was evidence of actions being implemented to prevent recurrence where possible. These are then signed off as complete by the BCM.</p> <p>Analysis of incident data occurs monthly to identify facility trends and then data is used to benchmark nationally with other Oceania facilities. Incidents/accidents are also discussed at quarterly regional cluster meetings. Specific learnings and results from incidents/accidents inform quality improvement processes. Meeting minutes confirmed that the BCM and CM share the results of incident analysis and discuss the impact of these at RN, quality/health and safety and staff meetings. Graphs which showed month by month trends and how this compares nationally are displayed in the staff room.</p> <p>The BCM and the CM described essential notification reporting requirements, including for pressure injuries. Documents showed there have been five section 31 notifications about pressure injuries made to the Ministry of Health, since the previous audit. Notifications for changes in governance, and executive and senior management have also occurred.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance</p>	FA	<p>Staffing management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation's policies are being consistently implemented</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation with competency assessments/performance review at set intervals following employment and then annually.</p> <p>St Johns Wood follows the Oceania approach to professional development which ensures that ongoing education is provided to all staff. Training records and interviews confirmed that all staff had undertaken a minimum of eight hours training each year which was relevant to their roles. Continuing education is planned and coordinated nationally each year. This includes role specific mandatory annual education and training modules that are provided via study days. Each facility also has the ability to implement other upskilling opportunities, such as using ‘tool box tutorials’ and inviting in guest presenters for specific purposes. There was written evidence of additional training on prevention and treatment of pressure injuries (PIs) to reduce the number of PIs in the facility. This contributed to the continuous improvement rating in criterion 1.3.6.1.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Of the 30 HCAs currently employed, 19 have completed Careerforce training to level 4, five are at level 3 and six have commenced level 1. There are designated internal assessors for the Careerforce education programme.</p> <p>Each of the RNs and a number of HCAs have current medication competencies and current first aid certification.</p> <p>Of the ten RNs employed, eight are maintaining their interRAI competencies.</p> <p>Education session attendance records showed that ongoing education is provided in topics relevant to the services delivered. The recently introduced electronic training register (LMS) readily identifies individual staff who are due to complete their required training and competencies. These include subjects such as: fire training; infection control; hoist use; restraint; medication management; and wound management. Each of the staff records sampled contained evidence that training and annual performance appraisals were up to date.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This meets the minimum requirements of the DHB contract. Interviews and rosters confirmed that staff levels are adjusted to meet the changing needs of residents. There is a small casual pool of HCAs available to supplement rosters when needed to accommodate increases in workloads. The CM</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>is available on call after hours, seven days a week. Staff reported that reliable access to advice is available when needed.</p> <p>Care staff and RNs said there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover is provided to meet current residents' acuity and bed occupancy, with staff replaced in any unplanned absence. Residents' needs were being consistently met in a timely manner. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage to meet the ARC requirements for hospital level care.</p> <p>St Johns Wood employs 64 staff. This consisted of the management team, RNs, health care assistants (HCAs), activities coordinators, maintenance personnel and household staff, such as kitchen, laundry and cleaning staff who provide services seven days a week.</p> <p>Rosters sighted reflected adequate staffing levels and showed there are at least two RNs on each morning and afternoon shift, who were supported by six to seven HCAs. There is one RN on each night shift supported by three experienced HCAs. Care staff respond to village residents' after hour's emergency call bell activations. The village apartments are under the same roof as the care facility. There have been less than two call bell activations in the past year.</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>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 on site for 12 months and are readily retrievable. They are then transferred offsite and 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>	<p>FA</p>	<p>Residents are admitted to St Johns Wood following assessment from the Lakes Needs Assessment Service (NASC), as requiring the level of care that St Johns Wood 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. All residents are admitted to the facility in accordance with current by MOH, COVID 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</p>

		demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.
<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 Lakes DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings and 'pink' envelopes for palliative care. 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 management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	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. Two RNs or one RN and one medication competent carer sign 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.</p> <p>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 with controlled drugs signed in. All registered nurses are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of ambient room temperature records taken.</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. There were no standing or verbal orders. Vaccines are not stored on site. Residents and staff have received the required COVID-19 vaccines with the exception of those</p>

		<p>who did not want to be vaccinated.</p> <p>There is a documented process for any residents who are self-medicating. This is decided in conjunction with the GP, RN and the resident. Self-medication documentation is completed by the GP and a copy is placed in the notes. At the time of the audit there were no residents self-administering medications.</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> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns was reviewed by a qualified dietician on 31 March 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 Ministry of Primary Industries which expires on 24 March 2022. At the 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 an electronic database.</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 food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>The recent resident satisfaction survey (8 September 2021) indicated some dissatisfaction with the meals. A corrective action plan was implemented and discussion with the residents and head chef took place and changes have been made. Family/whānau interviews evidenced satisfaction with the meals. 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</p>	FA	<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 the NASC service, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care. Examples of this occurring were discussed with</p>

<p>consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>the clinical manager and the regional quality clinical manager.</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 the NASC and a new placement is found in consultation with the resident and the whānau/family.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission to St Johns Wood, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition and activities to identify any deficits and to inform initial care planning. Within three weeks of admission, residents (except for respite, ACC and YPD residents) are assessed 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</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at St Johns Wood are electronic. 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 documented, 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>
<p>Standard 1.3.6: Service</p>	<p>CI</p>	<p>Documentation, observations and interviews with residents and families verified that the care</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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. The service has gone beyond this by implementing a program specifically aimed at reducing the number of pressure sores within the facility. Staff were educated and empowered to utilise equipment and resources which achieved the desired result. This is rated continuous improvement.</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 one full time activities assistant and two part time assistants, who support the residents Monday to Friday 8.00am till 4.30pm in the rest home and hospital. For Saturdays and Sundays, one activities assistant is available in the rest home and hospital from 10am – 3.00pm. The programme is overseen by a diversional therapist who will precept each assistant to complete the qualification should they wish too.</p> <p>An activities assessment is completed 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 and documented as part of a six monthly multidisciplinary care plan review. Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', crafts, visiting entertainers and a daily walking group. A variety of public holidays are celebrated along with resident's individual birthdays.</p> <p>There is a facility vehicle available to take residents out. Prior to COVID-19 restrictions this was every day, but at the time of the audit it was three days per week. There are several lounge areas, 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 throughout the facility and each resident is given a copy of the weekly activities plan showing what is available for them to participate in. Residents and families have the opportunity to evaluate the programme through day to day discussions with the activities co-ordinator and by completing the six-monthly 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>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. 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, and 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/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. 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 district nurses for specialist wound care. The resident and the family/whānau 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>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and 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 to provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment which staff were observed to be using during the audit.</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</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 08 October 2021) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Evidence that this occurs was confirmed in documentation reviewed, interview with the maintenance manager and observation of the environment. There is an extensive monthly planned maintenance schedule which is reliably attended to by</p>

<p>their purpose.</p>		<p>maintenance personnel. Testing and tagging of electrical equipment is carried out by the full time employed maintenance person who is a registered electrician. Testing and calibration of bio medical equipment occurred in April 2021. The environment was hazard free and resident safety was promoted. External areas were confirmed as being safely maintained and were sighted as appropriate to the resident group and setting.</p> <p>Staff and residents said they knew the processes to follow when repairs or maintenance are required and said their requests are actioned in a timely way. This was confirmed by sighting entries in the maintenance request book and interview with maintenance staff.</p> <p>Residents and family members were happy with the environment.</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 were adequate numbers of accessible bathroom and toilet facilities throughout the facility. Each resident has use of their own fully accessible bathroom and toilet. There are additional staff and visitors' toilets located throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Hot water temperature testing occurs regularly, and the records showed that all water temperatures were within a safe range, for example, no higher than 45 degrees Celsius in resident accessible areas and slightly higher than 60 degrees Celsius in the kitchen and laundry.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around and within their bedrooms safely. All of the 24 standard rooms provide for a single occupant as does two of the 38 care suites. Thirty six of the current care suites could accommodate a couple. There were no couples on site during the audit. All bedrooms/care suites are currently located on the ground floor. Conversion of upstairs village apartments to care suites is underway and will occur as independent living village residents vacate their apartments or transfer to care. Rooms are personalised with furnishings, photos and other personal items displayed.</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</p>	<p>FA</p>	<p>A variety of communal areas are available for residents to engage in activities. The ground floor has two spacious dining rooms and at least two lounge areas. These are centrally located to enable easy access for residents and staff. There are sufficient private and quiet spaces available for residents to access for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>

relaxation, activity, and dining needs.		
<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>Laundry is undertaken on site by dedicated laundry staff who are on site seven days a week. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>All designated laundry and cleaning staff have attended training in safe chemical handling as confirmed in interview with staff and their training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. There are now cleaners on site seven days a week. Three cleaners work Monday to Friday for seven hours each and one cleaner on Saturday and Sundays for five hours a day.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. The chemical provider who visits regularly also provides staff education/information and tests the effectiveness of their products.</p> <p>There have been no issues, complaints or staff injury related to cleaning and laundry.</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>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff.</p> <p>Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service when it was reviewed in 2009. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 04 June 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQs, were sighted and meet the National Emergency Management Agency recommendations for the region. Water storage tanks and potable water is stored onsite, and there are effective systems for managing power outages. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no concerns about security reported.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All bedrooms have appropriately sized opening external windows which provide sufficient natural light. Each of the care suites have sliding door access to outdoor areas.</p> <p>Heating in residents' rooms and in the communal areas is provided by radiators which can be individually temperature adjusted. These radiators are fed by gas fired boilers.</p> <p>All areas were warm and well ventilated throughout the audit and residents and families confirmed that the home is maintained at a comfortable temperature regardless of the weather.</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>St Johns Wood implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The registered nurse is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the COVID-19 pandemic emerged.</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. 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 that details all the actions required by the service streams within the facility in response to each of the alert levels. The ICN and the quality manager confirmed the availability of resources to support the programme and any outbreak of</p>

		an infection.
<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 and clearly documents on each policy the next review date.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitises, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitizer 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 collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and St Johns Wood 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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, the restraint register recorded one resident was using a chair brief and bed rails as restraint and one other resident required a chair brief for safety when sitting. There were two residents using bed rails at their request as enablers.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on observation of the environment, review of the restraint approval group minutes, files reviewed, and from interviews with staff.</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, made up of the restraint coordinator, other RNs, the BCM, CQM (if needed) and NP and/or GP are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint committee meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was documented. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN restraint coordinators undertakes the initial assessment with input from other RNs and the resident's family/whānau/EPOA. The RN/restraint coordinator and CM interviewed described the documented process. Families confirmed their involvement. The NP or GP is always involved in the final decision for use of restraint.</p> <p>The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the residents who were using restraints.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are used with input from staff and family members (eg, the use of sensor mats, low beds and fall out mattresses).</p> <p>Regular (two hourly) monitoring of bed rails and hourly checks/monitoring of residents in chair briefs occurs to check the resident is safe. Records of monitoring sighted had the necessary details. Access to advocacy is provided if requested and processes ensure dignity and privacy are respected.</p> <p>A restraint register is maintained, updated and reviewed at two monthly restraint group meetings. The register reviewed, contained sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff interviewed understood that the use of restraint is to be minimised and how this is maintained 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 their use of restraints was being reviewed and evaluated during care plan and interRAI reviews, two monthly restraint evaluations and at the restraint committee meetings.</p> <p>The evaluation included all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<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>Regular restraint evaluations and reviews are completed, and individual use of restraint use is reported to the quality committee and staff meetings. Minutes of meetings 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 education and feedback from the doctor, staff and families. A six-monthly internal audit also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.</p> <p>Data reviewed, minutes and interviews with the CM, CQM and restraint coordinators confirmed that the use of restraint has reduced from five to two since January this year.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	CI	<p>Between June 2019 and December 2020, there were 28 pressure injuries either facility acquired, or residents had been admitted with them, four of these were of a grade 2 or above. Investigations revealed more equipment and new resources were required. Training and education on specialist equipment and supplies to prevent pressure injuries, was conducted along with an awareness on prevention and improved management of pressure injuries. This included daily monitoring of skin, three-day continence assessments, high protein drinks, two hourly toileting and advice from the GP and wound care nurse on who was at risk of a pressure injury.</p>	<p>Focused education and new resources has enabled staff to readily identify and manage those residents vulnerable to pressure injuries. This has succeeded in reducing the number of pressure injuries from 28 (in an 18 month time period) to six, grade 2 and below in the previous six months. Residents have improved quality of life and staff described being able to better manage these injuries in the future. The DHB has commented positively on the success of one particular resident's pressure injury.</p>

End of the report.