Cambridge Resthaven Trust Board Incorporated - Cambridge Resthaven

Introduction

This report records the results of a Surveillance 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:	Cambridge Resthaven Trust Board Incorporated
Premises audited:	Cambridge Resthaven
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 November 2021 End date: 25 November 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: 60

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Cambridge Resthaven (who now refer themselves as Resthaven on Vogel provides rest home, dementia and hospital level care for a maximum of 92 residents. On the days of audit 60 beds were occupied. The service intends demolishing two wings with older style bedrooms and these rooms are not being used. The service is operated by Cambridge Resthaven Trust Board Incorporated and managed by a long serving chief executive officer (CEO), a general manager, a director of nursing and a clinical nurse leader.

The Board purchased a nearby aged care facility in early 2020. Other changes since the previous certification audit in September 2019 are a reduction in the number of dementia level beds from 20 to 10, and an increase in the number of dual purpose beds from 66 to 70. The service has also transitioned from paper records to an electronic consumer and quality management information system.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the service provider's contract with Waikato District Health Board (WDHB). The Ministry of Health requested additional standards be included to assess the effectiveness of actions taken in response to an investigation in 2019. These are commented on in standard three (The Continuum of Service Delivery) of this report.

The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner. All interviewees spoke positively about the care provided.

There were no non-conformities identified during this audit. Sufficient evidence was presented to show that the corrective action required at the last audit had been implemented, regarding hot water temperature monitoring, as have the actions required from the investigation outcome.

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.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. On the days of audit there were no residents who required alternative forms of communication.

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.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes internal audits, and the collection and analysis of quality improvement data. This is benchmarked with seven other facilities and identifies 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 and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. 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.

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.

The service is delivered in a manner that provides continuity and promotes a team approach for the care of the residents. There are policies and procedures in place, which support assessment, planning, provision of care, evaluation, and transfers for residents. These safely meet their needs and the facility's contractual obligations.

The multidisciplinary team includes a general manager, clinical nurse leader, registered nurses, and several facility GPs who assess the needs of the resident on admission. Care plans are individualised, and resident focused with interRAI assessments completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner.

The service provides a planned activity programme which has a variety of individual and group activities and maintains links with the community as COVID-19 allows.

The medication policy is based on current best practice for medication management and the staff who administer the medications are competent to do so

The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. The service has a four-week rotating menu which has been approved by a registered dietitian.

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.

There have been no changes to the structure of the buildings since the previous audit. Building improvements for safety and enhancements are ongoing. There is a current building warrant of fitness. A number of rest home bedrooms are scheduled for demolition and are not being used.

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.

Staff have implemented policies and procedures which prevent and minimise the use of restraint interventions. Two restraints and two enablers were in use at the time of audit. The service is successfully preventing and minimising the use of restraints.

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 control programme is led by an experienced and trained infection control nurse and aims to prevent and manage infections. The infection control policy identifies current best practice for infection control management. Aged care specific infection surveillance is undertaken, data is collated monthly and presented at the quality meeting, registered nurse meeting and general staff meeting. Staff demonstrated good principals and practice around infection control, which is guided by relevant policies and supported with regular education

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	0	0	0	0
Criteria	0	43	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 how to raise concerns and would not hesitate to do so. Staff confirmed their understanding of the complaint process and said they always refer complainants to the GM who is responsible for the management of these. The electronic complaints register recorded 13 complaints and concerns received from residents and family members since November 2019 plus another eight complaints from staff about other staff or system concerns. Interview with the GM and documents sighted showed that prompt and appropriate actions were being taken. Evidence was sighted that showed all parties were kept informed throughout the process until resolution was achieved. Improvements or changes required as a result of complaints were being implemented where possible. The service provider has implemented a range of improvements and corrective actions as a result of the complaint submitted by a family in 2019. These include ensuring all residents and/or their authorised representative have engaged in advance care planning, that any staff member who notices even the smallest change in a resident reports these immediately on a ‘Stop and Watch’ form and sepsis screening and action tools are in place.

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/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. The open disclosure policy meets the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and staff clearly described the various ways they maintain frank and honest communication and adhere to the principles of disclosure. Staff knew how to access interpreter services, although this is rarely required as all residents speak English. A previous non-verbal resident was supported to communicate using software communication and gestures.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Cambridge Resthaven Trust Board Incorporated follow a strategic roadmap which documents the purpose, values, scope, aims and priorities of the organisation. This is linked to the annual quality plan and risk management plan. The service is managed by a chief executive officer (CEO) who has been in the role for approximately 20 years and is responsible for the overall Cambridge Resthaven Trust activities. The CEO reports to a board of trustees. There are currently seven members on the board. Overall care and resident services are overseen by the general manager (GM) who is a registered nurse. This person has been in the role for 12 years and holds a post graduate diploma in management studies. The GM's responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM attends at least eight hours of professional development per annum related to managing an aged related residential care facility as required by the District Health Board (DHB) agreement. The GM and the CEO provide monthly reports to the trust board. The sample of reports sighted included information to monitor performance, including occupancy rates, staffing numbers, emerging risks and issues, incidents and accidents, concerns, compliments and complaints, health and safety and equipment / facility issues. The CEO, GM and the board maintain knowledge of the sector, regulations and reporting requirements by attending external forums and regular meetings with other aged care managers in the Community Trust Care Association (CTCA). This is a business entity of rurally located, not for profit aged care providers. The facility has an Aged Related Residential Care Contract with Waikato DHB for the provision of rest home, hospital and dementia care services. There were sixty residents receiving care under this contract. Twenty six had been assessed as requiring rest home level care, 25 at hospital level care and nine at dementia level. There were no residents receiving respite/short term care and none under the Long Term Support-Chronic Health Care agreement. The service also has a Young People with Disabilities (YPD) contract with the Ministry

		of Health for the provision of rest home and hospital level care. Of the five residents receiving care under this contract, there were four receiving hospital care and one at rest home level of care. Only two of these residents were still under the age of 65 years.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents including infections and complaints, audit activities, regular resident and family satisfaction surveys, internal audits and the monitoring of outcomes. All incidents/accidents, infections, restraints and complaints are collated as quality data, analysed and compared month by month for trends. An overview of this data is reported to the board each month. A sample of meeting minutes confirmed that this data and other related information is also discussed at the weekly senior leadership/management team meetings, and to the monthly health and safety meetings, registered nurse (RN), health care assistant (HCA) and full staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at their meetings. The service continues to benchmark quality data with the seven other aged care facilities who form part of the CTCA group and also benchmarks with their 'sister' facility Resthaven on Burns, which provides the same type of aged care services but with less beds. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Results of the most recent survey showed a high level of satisfaction and no significant issues. The sample of policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Interviews with all members of the senior leadership/management team demonstrated how they monitor and manage risks, and their responsibilities under the Health and Safety at Work Act (2015). There had been no staff injuries that required reporting to Worksafe NZ since the previous audit in September 2019.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported	FA	Staff document adverse and near miss events on an accident/incident form. The sample of incident forms reviewed revealed these contain all necessary information including who had been notified of the event. All incidents are reviewed by the clinical nurse leader and then signed off by the GM. Where further investigation or improvement is required, corrective actions are developed and implemented in a timely manner then monitored for improvement before being closed off. A range of adverse event data, for example, falls-with and without injury, urinary tract infections (UTIs) and skin tears, is collated and reported to CTCA for benchmarking

to affected consumers and where appropriate their family/whānau of choice in an open manner.		each month. The GM compiles month by month data analysis reports for the board and these are presented, and trends discussed at all staff meetings. Senior clinical staff demonstrated an understanding about essential notification reporting requirements. One notification of a stage 4 pressure injury has been submitted to the Ministry of Health and DHB since the previous audit. A change of Board members was notified in December 2020. There had been no police investigations or issues-based audits.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes police and referee checks, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records confirmed that the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records showed documentation of completed orientation and a 'catch up chat' with the education/training officer within the first 90 days of employment. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the total 39 HCAs employed, five had achieved level 4 of the national certificate in health and wellbeing, eight had achieved level 3 and one had achieved level 2. Six HCAs were progressing educational achievements. Ten HCAs, seven RNs and an enrolled nurse (EN) have completed the education modules required for work in dementia care. New elements of staff education, following the 2019 investigation include early sepsis identification, stop and watch initiatives for deterioration or changes in residents, and reinforcing the importance of pain assessment and pain management and advance care planning. Eleven of the twelve registered nurses employed were maintaining their annual competency requirements to undertake interRAI assessments. One enrolled nurse (EN), whose assessments are checked by an RN, also conducts interRAI assessments, as does the CNL. The staff education officer is accredited to provide training on interRAI and other educational standards. Each of the staff records reviewed contained evidence of attendance at regular training and participation in an annual performance appraisal. All of the RNs hold current first aid certificates and are peer assessed annually for medicine competencies.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staff working in the dementia unit have completed a dementia care related industry approved qualification or are working towards this as required to meet the provider's DHB contract The Nurse Director (ND) works 40 hours a fortnight and the clinical nurse leader (CNL) works 36 hours a fortnight. A staff educator (SE) is on site at least three days a week. In addition to the GM, CNL and SE, there are 12 registered nurses employed. There are 39 health care assistants which includes five team leaders (one is an enrolled nurse). Catering and cleaning services are provided by contractors. The facility adjusts staffing levels to meet the changing needs of residents. The GM calculates the staff ratio to level of care/resident numbers each month and this is reported to the CEO and the board. This data reveals more than adequate numbers of staff. Staff rosters confirmed that in addition to the CNL, the ND and GM, there are two RNs and seven to eight HCAs allocated for each morning and afternoon shift. There is usually another registered nurse on site carrying out assessments, updating care plans, and ensuring that GP reviews and communication with residents and their families has occurred for the eight to ten residents they have responsibility for a 'keyworker' role. The RNs manage their own duties in agreement with each other, to cover on the floor shifts and complete the paperwork required for their allocated residents. One RN and three HCAs are rostered for night shifts. There is always a minimum of two caregivers in the dementia unit and one at night. Nursing/clinical advice is available 24 hours a day, seven days a week (24/7) from any of the senior clinicians, such as the GM, ND or CNL. The RNs interviewed said they can always access additional advice when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of three weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff are rarely used. Three volunteers who assist with the diversional therapy and activities programme work under the oversight of the diversional therapy team. At least one staff member on duty (the registered nurse) has a current first aid certificate. Diversional therapy staff or driver involved with taking residents on outings also have a first aid certificate. The increase in dual purpose bed numbers has not impacted staffing. The four rooms are still occupied by independent living ORA (occupational right agreement) residents, of whom one is receiving rest home level care. The reconfiguration request to approve these rooms as dual purpose was to provide a continuum care for these residents.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurses on night duty sign in the medications against the prescription. 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 three-monthly stock checks and accurate entries with controlled drugs signed in. All registered nurses are competent with syringe drivers. The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit. 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 are no standing orders or verbal orders. Vaccines are not stored on site. Residents have received the required COVID-19 vaccines except for those who did not want to be vaccinated. There is a documented process for any residents who are self-medicating. This is decided in conjunction with the GP, registered nurse 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-medicating. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of	FA	The food service is provided on site with a company contracted to deliver this service and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in October 2021. 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 Industry. At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and

service delivery.		recorded as part of the plan using an electronic recording system. 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. Staff confirmed that any weight loss in residents is immediately flagged for follow up by the Director of Nursing and GPs, referrals to dieticians occur and actions recommended for supplements are implemented if required. The kitchen provides a varied menu which supports residents with specific food requirements. Special equipment to meet resident's nutritional needs, is available. Residents and family/whanau interviewed, expressed satisfaction with the variety of the menu. There are snacks available twenty hours a day for residents with a selection of fruit, baking, cereals, toast, and trays of sandwiches also made for those residents in the dementia unit. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents of Resthaven on Vogel Street are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, activities, mobility, to identify any deficits and to inform initial care planning. Within 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 at the multi-disciplinary meeting (MDT) or more frequently as residents changing conditions require. The facility has implemented a number of new assessment tools relating to signs of clinical deterioration and pain management following an investigation, these being Sepsis Screening and Stop and Watch, if there has been a change noticed in the resident. This is then passed onto the RN through the progress notes. Each nurse has a copy of the Health Quality & Safety Commission's Frailty Care Guides, this is also available electronically. 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. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service	FA	Care plans at Resthaven on Vogel Street are all electronic. When reviewed they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. Short term care plans are not used, as care plans are updated electronically and reflected in the progress notes. Wound and skin management plans were sighted in the residents' electronic files. The needs identified by the interRAI assessments were reflected in the care plans reviewed. Care plans evidenced service integration with progress notes, activities note, medical and allied health

delivery.		professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. The electronic file reviewed in the dementia facility had a detailed 24-hour behavioural plan in place specific to the residents' individual needs. Residents and family/whanau reported participation in the development and ongoing evaluation of care plans at the six monthly (MDT) meetings. There are fortnightly RN meetings with case reviews of residents with particular attention and discussion around those who are declining or have more complex needs. Following an investigation, all residents now have some form of advanced care plan documented, depending on their wishes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews with residents and families verified that the care and interventions 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 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 and registered nurses confirmed that care was provided as outlined in the documentation and the new processes and assessments implemented had been very successful. A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by two full time qualified diversional therapists who support the rest home, hospital, and dementia residents Monday to Friday 8.00 am till 3.30 pm. The facility is currently spilt into five pods due to current COVID-19 restrictions and to help minimise any risk of the spread of the virus to the residents, if it enters the facility. Diversional therapy staff are supported by the carers who are set up with an activities box and access to the 'Golden Carers' website. Activities are left for the residents over the weekend. The file reviewed for the (YPD) resident included activities specific to their needs (eg, beauty therapy, dog therapy, music of their choice and facilitated walks with family or staff). For those residents in the dementia facility there is a 24-hour diversional therapy plan for staff to utilise should the need arise. 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 plan is evaluated through daily observation to assess levels of participation, is documented every three months, and forms part of a six-monthly (MDT) care plan review. There is a yearly survey for residents and families to complete. Residents interviewed confirmed the programme was interesting and varied. It is the aim of the diversional therapist to get the residents engaging in the community as much as possible,

		and they are encouraged to join clubs outside in the community, for example, the 'Stroke Club'. Within the facility, there are 10 different clubs which the residents choose to join, some of these are the baking, beauty, men's, and women's clubs. There is a facility van available for drives on a Thursday for the more able residents and a Friday for those with restricted mobility. Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, dog therapy, exercises and visiting entertainers as COVID-19 restrictions allow. Hospital and rest home residents have the same activity programme. The programme in the dementia facility is more 'fluid' and subject to change depending on the needs of the residents. There are several lounge areas, as well as the individual's bedrooms where they can 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted through the 'Stop & Watch', it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly InterRAI reassessment and the multi-disciplinary team meeting, 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. 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 evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with expiry date 12 May 2022 is publicly displayed. There had been no changes to the physical layout of the building. The improvement regarding the hot water outlets being regularly tested which was identified at the last audit is now resolved. Interview with the property manager and sighted hot water monitoring records confirmed that between 30 and 53 outlets are checked monthly. The temperatures are within an acceptable range (no more than 45 degrees Celsius) The reduction in dementia bed numbers from 20 to 10 and the increase in dual purpose bed numbers (from 66 to 70) has not significantly impacted service delivery. The four independent living apartments that were previously assessed as suitable for rest home level care, are also appropriate for hospital level care. These are of a generous size and have disability accessible bathrooms. Staff allocations are flexible to meet the acuity

		needs of residents, and the ratio of staff to residents is monitored. Housekeeping and food services has not been impacted.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities 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, staff can view laboratory results in the electronic patient management system to ensure early intervention occurs. 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 Resthaven on Vogel Street have processes in place to manage the risks imposed by COVID-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service provider's policies meet the requirements of these standards and provide guidance on the safe use of both restraints and enablers. On the days of audit, the restraint register listed two residents using bed rails and/or lap belts as restraint interventions and two residents (one using a bedrail and one using a lap belt) as enablers. These were the least restrictive and used voluntarily at their request. The same consent, assessment and monitoring processes are followed for the use of enablers as is used for restraints. Observations, interviews and documents confirmed that restraint is used as a last resort when all alternatives have been explored. Resthaven on Vogel continues to actively prevent and minimise the use of restraints. The CNL/restraint coordinator regularly monitors and reports restraint trends. Use has decreased since the previous audit in 2019 when five restraints were in use.

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.

No data to display

End of the report.