Claud Switzer Memorial Trust Board - Switzer Residential Care

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 Health and Disability Auditing New Zealand 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:	Claud Switzer Memorial Trust Board
Premises audited:	Switzer Residential Care
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: 15 August 2017 End date: 16 August 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 89

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

Switzer Residential Care provides rest home, hospital and dementia level of care for up to 91 residents. On the day of the audit there were 89 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner

The trust board employs a general manager (RN), a facility manager, a human resources/administration manager and a nurse manager to implement the strategic plan and oversee the day-to-day operations of all services. The general manager and nurse manager are well qualified for their roles. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. The residents and relatives spoke positively about the care and supports provided at Switzer residential care.

The service is achieving two continuous improvement ratings relating to good practice and falls reduction.

Consumer rights

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

Switzer Residential Care provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

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.

Switzer Residential Care has implemented a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality assurance (QA) meetings. An annual resident satisfaction survey is completed and there are monthly resident meetings. Quality performance is reported to staff at the three-monthly meetings and includes a summary of incidents, infections and internal audit results. There is a health/safety and risk management programme in place. There are human resources policies including recruitment, selection,

orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes.

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.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified that the integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. The activities team implements a varied activities programmes to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are regular entertainers, outings and celebrations. Medications are managed appropriately in line with accepted guidelines. Registered nurses and enrolled nurses who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner. Residents' food preferences and dietary requirements are identified on admission and all meals are cooked on-site. This includes consideration of any particular dietary preferences or needs.

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 is a current warrant of fitness and an approved fire evacuation plan. There is at least one staff member on each shift with a first aid certificate. Rooms are single accommodation with the exception of one double room in kowhai wing. Bedrooms in three wings have their own ensuite. There are adequate communal toilets and showers. The home is warm and resident rooms are personalised. There is a large central lounge area and a spacious dining room in the main hospital/rest home and dementia areas. There are effective waste management systems in place and chemicals are stored safely. The facility has a van available for transportation of residents. Staff that transport residents hold current first aid certificates. Activities occur throughout the facility. Dedicated staff manage cleaning and laundry services. There are systems in place for emergency management and there is at least three days of emergency supplies stored on-site. All key staff held a current first aid certificate. The facility is light and ventilated. Solar heating supplies the dementia wing with heated wall panels throughout the facility and underfloor heating in two wings. The facilities manager monitors internal temperatures. There is a designated smoking area within the grounds.

Restraint minimisation and safe practice

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

There is a documented definition of restraint and enablers that align with the definition in the standards. There is a restraint register, which also records residents who require the use of an enabler. The restraint approval process is undertaken with the resident, family and other health professionals. All parties sign restraint consent forms. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. On

the day of audit there were nineteen residents with restraint and eight residents with an enabler. Staff receive training in restraint minimisation and challenging behaviour management.

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.

Switzer Residential has an infection control programme that complies with current best practice. There is a dedicated infection control nurse who has a role description. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated biannually into the annual training programme. Training records were sighted. Education provided, includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

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	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Families and residents are provided with information on admission which includes the Code. Interviews with fifteen care staff; six registered nurses (RN), two enrolled nurses (EN), five healthcare assistants (HCA) and two diversional therapists, who work across rest home, hospital and dementia demonstrate an understanding of the Code. Ten residents interviewed (five rest home and five hospital) and three relatives (one rest home and two hospital) confirm staff respect privacy, and support residents in making choice where able.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Ten resident files sampled (four rest home including one respite and one young person's disability, four hospital and two dementia including one on a long-term support chronic health conditions), demonstrated that advance directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Healthcare assistants and RNs interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All ten resident files sampled had an admission agreement signed on or before the day of admission and consents.

to make informed choices and give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code and Advocacy pamphlets on entry. Interviews with the general manager and nurse manager confirm practice. Residents interviewed confirm that they are aware of their right to access advocacy. Discussions with relatives confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks. Staff receive education and training on the role of advocacy services.
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	Interview with 10 residents and three relatives confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Residents interviewed confirm the activity staff help them access the community such as going shopping, going on sight-seeing tours, and going to church. There are two residents on YPD contracts and are engaged in a range of diverse community activities including (but not limited to) health and wellness, social groups and community outings.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice. The general manager leads the investigation and management of complaints (verbal and written). There is a complaint (and compliments) log/register that records activity in an ongoing fashion. Complaints are discussed at the monthly QA meeting. Complaints forms are visible around the facility on noticeboards. Three complaints were made in 2016 and two received in 2017 year-to-date. All complaints reviewed had been investigated and closed out. The general manager (who is also the quality coordinator) completes a six-monthly review of complaints and trends as part of the quality programme (the review for January to June was sighted). Discussion with residents and relatives confirm they are aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights	FA	There is a welcome pack that includes information about the Code and with the opportunity to discuss prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy

During Service Delivery Consumers are informed of their rights.		information are displayed throughout the facility. The monthly resident meetings also provide the opportunity for residents to raise issues (minutes sighted). Residents and relatives interviewed informed that information has been provided around the Code. The general manager and nurse manager stated that they have an open-door policy for concerns or complaints. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. Abuse and neglect training was provided to staff in May 2017. Young people with disabilities (YPD) can maintain their personal, gender, sexual, cultural, religious and spiritual identity.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Switzer Residential Care has a Māori health plan (2013 – 2018) in place. There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. The service has as a quick reference flip chart (Tikanga Recommended Best Practice Standards/Guidelines) in place that provides guidance for staff on culturally acceptable practice. The flipchart includes seven standards and covers the following aspects: karakia, taonga/valuables, information and support, whānau/family support, food, linen and bedpans, body parts/tissues/substances and following death. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups (ie, Kuia and Kaumātua group) who visit regularly and involve the Māori residents in cultural activities. Cultural needs are addressed in the care plan (one Māori resident file reviewed). At the time of audit, the staff report there were approximately 14 residents that identify as Māori. Interviews with two Māori residents informed their cultural needs are met. There are policies being implemented that guide staff in cultural safety. Special events and occasions are celebrated and this could be described by staff.
Standard 1.1.6: Recognition And Respect Of The	FA	The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform that values and beliefs are

Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		considered. Residents interviewed confirm that staff take into account their culture and values.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in staff files. Staff meetings occur four-monthly and include discussions on professional boundaries and concerns as they arise (minutes sighted). Management provide guidelines and mentoring for specific situations. Interviews with the nurse manager, RNs and ENs confirm an awareness of professional boundaries. Interview with HCAs could discuss professional boundaries in respect of gifts.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Switzer Residential Care has a suite of appropriate policies and procedures that are updated as necessary. There is an established quality improvement programme that includes performance monitoring against clinical indicators. Switzer Residential Care is part of the Far North Quality and Benchmarking Group that is made-up of five residential facilities within the region. Benchmarking is undertaken as part of the Far North Quality & Benchmarking Group. The group meets three-monthly. "First do no harm" benchmarking through the Northland DHB around pressure injuries and falls. There is an education coordinator (RN) who works 20 hours/week. There is an estimated 21 (of 38) care staff with national certificates and the remaining 17 are progressing towards a qualification. There is evidence of education being supported outside of the bi-annual training plan such as palliative care training for HCAs and attendance at in-service offered via the DHB. There is a 'train the trainer' programme in place that includes a 16-week in-service programme, the HCAs spoke very positively about the programme.
Standard 1.1.9: Communication Service providers	FA	There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Thirteen incident forms reviewed across July/August 2017 identify family were notified following a resident incident. Interview with HCAs, RNs and ENs

communicate effectively with consumers and provide an environment conducive to effective communication.		advise family are kept informed. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and this can be read to residents.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Switzer Residential Care provides care for up to 91 residents across three service levels (rest home, hospital and dementia care). The 91 beds comprise of 25 designated rest home beds, 30 designated hospital beds, 21 dual-purpose rest home/hospital beds and 15 designated dementia beds. The facility is split into five wings, the Puriri wing (dementia care) has 14 of 15 residents, Kauri wing (rest home) has 19 of 20 residents, Millie wing (dual-purpose beds) has 16 of 16 residents, Kowhai wing (hospital) has 23 of 23 residents and Matai wing (dual-purpose beds) has 17 of 17 residents. On the day of audit there were 89 residents in total, 39 rest home level residents, 36 hospital level residents and 14 dementia care residents. The majority of residents are on the aged residential related care (ARRC) contract except two YPD residents and one respite resident in the rest home. Also two residents on long-term support chronic health condition contracts (LTSCHC) in the dementia unit. Switzer Residential Care is a charitable trust with a board of three trustees. There is an advisory group (that includes a Kaumātua and wide representation within the community) who meet with the board of trustees quarterly. The general manager meets monthly with the board of trustees. There is a strategic plan (2016 – 2021) that includes long-term goals, vision, mission and philosophy. Goals include critical success factors and outcomes. There is an annual business, quality improvement and risk management plan (April 2017) that details all aspects of the quality programme. Benchmarking is undertaken as part of the Far North Quality & Benchmarking Group. The group meets three-monthly. “First do no harm” benchmarking through the Northland DHB around pressure injuries and falls. The service is managed by an experienced RN who has been the general manager at Switzer Residential Care for 19 years. The general manager is supported by a nurse manager who has been with Switzer Residential Care for 17 years as an RN and has been in the current role for eight years. There is a team of RNs who have experience within the aged residential care environment. The general manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.
Standard 1.2.2: Service Management	FA	During a temporary absence, the nurse manger will cover the general manager’s role (and vice versa). Both the general manager and nurse manager are experienced RNs.

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.		
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	Switzer Residential Care is implementing a quality and risk management system. Policies are reviewed on a regular basis; review dates are recorded in the footer on policy documents. Quality matters are taken to the monthly Quality Assurance (QA) meetings that comprise a core group of staff. Quality Assurance meeting minutes demonstrate key components of the quality management system are discussed including (but not limited to) internal audits, infection control, incidents (and trends). The quality coordinator is the general manager. Monthly meeting minutes are included in the board 'packs' to keep them appraised of clinical/operational matters/risk/initiative. Meeting minutes reviewed indicate issues raised are followed through and closed out, including monthly resident meetings. Switzer Residential Care is implementing an internal audit programme that includes aspects of clinical care, such as documentation review. Issues arising from internal audits are recorded as having been resolved with implementation reviewed at the next scheduled audit. There were a small number of corrective action plans (signed and closed out) on file. There is a health/safety and risk management programme in place including policies to guide practice. The hazard register is reviewed annually. The service strives to maintain effective communication through the facility, which has seen the establishment of a 'team communicators' meeting structure. This involves a representative from each wing and each department. The group meets monthly and it is the responsibility of the representative to feed information back to the respective teams. The HCAs interviewed informed this forum provides the opportunity to have involvement in service matters. The meeting is facilitated and minuted by the human resources manager (interviewed). The general manager reports this structure essentially 'equalises' all staff groups and supports distribution of relevant information. The service completes staff newsletters three-monthly and an annual staff survey.
Standard 1.2.4: Adverse Event Reporting	FA	Incident/accident data has been collected and analysed. Incident forms are completed by care staff and the resident is reviewed by the RN at the time of event. The form is reviewed by the nurse manager and forwarded to the general manager for final sign off. An RN conducted clinical follow-up of residents in all fifteen incident forms reviewed and demonstrated investigation of incidents to identify areas to minimise the risk of recurrence. Interview

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.		with staff inform incidents/accidents are reported appropriately. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. HealthCERT and public health notifications were sighted for a norovirus outbreak in March 2017 (link 3.5).
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	There are human resources policies to support recruitment practices. Eleven staff files were reviewed, one nurse manager, two RNs (the infection control coordinator and restraint coordinator), four HCAs, one chef, one diversional therapist, one laundry and one EN, all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed. A list of practising certificates is maintained. The service has an education coordinator who is responsible for ensuring the orientation programme is completed for new staff. There is a buddy system for new staff and a 'train the trainer' programme being implemented. Staff interviewed (five HCAs, six RNs and two ENs) were able to describe the orientation process and believed new staff were adequately orientated to the service. They informed the period that a new staff member is buddied this can be extended if needed. There is a one yearly education plan that includes all required education as part of these standards. The plan is coordinated by the education coordinator (RN) who works 20 hours/week. Compulsory study days are offered seven sessions throughout the year and staff are required to attend one day annually. These days are called 'make it happen' and includes the following topics: moving and handling, falls prevention, fire evacuation/training, occupational health and safety, code of rights, infection control and resuscitation. Staff are able to make suggestions on additional topics for inclusion in the in-service calendar. There is evidence that additional training opportunities are offered to staff such as attendance at a palliative care series. Training attendance is recorded on a database (sighted), and the education coordinator undertakes a reconciliation of attendance annually (June 2017). This process ensures staff are meeting compulsory requirements and from the information reviewed all staff have attended a 'make it happen' study day within the last year. There is evidence on RN staff files of attendance at the RN training day/s and external training. There is an estimated 21 (of 38) care staff with national certificates and the remaining 37 are progressing towards a qualification. A competency programme is in place with different requirements according to work type (eg, HCA, RN, and kitchen). Competencies are completed and a record of completion is maintained in the database. Medication competencies are completed for RNs and ENs and are current at the time of audit. Staff interviewed are aware of the requirement to complete competency training.

		There are 12 HCAs that work in the dementia care unit, ten had completed the required dementia standards and two were in progress of completing. The two yet to complete the qualifications have been employed within the past 12 months.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager (RN with a current APC) and nurse manager alternate on-call. The two activities staff work Monday to Friday. The HCAs, residents and relatives interviewed, inform there are sufficient staff on duty. The facility is split into five wings, the Puriri wing (dementia care) has 14 residents, Kauri wing (rest home) has 19 residents, Millie wing (dual-purpose beds) has 12 hospital and four rest home residents, Kowhai wing (hospital) has 20 hospital and three rest home residents and Matai wing (dual-purpose beds) has four hospital and 13 rest home residents. Across the service, there are two RNs and one EN on duty on the morning shift, two RNs on the afternoon shift and one RN on the night shift. The RNs are supported by adequate numbers of HCAs. In Puriri there are two HCAs on duty on the morning and afternoon shifts and one HCA on the night shift. In Kauri, there are two HCAs on duty on the morning shift, one HCA on the PM shift and one HCA on the night shift (shared with Millie). In Millie there are three HCAs on duty on the morning shift, two HCAs on the afternoon shift and one HCA on the night shift (shared with Kauri). In Kowhai, there are five HCAs (various times) on duty on the morning and afternoon shifts and one HCA on the night shift. In Matai, there are two HCAs on duty on the morning and afternoon shifts and one HCA on the night shift. Additionally, there is one HCA on the morning shift available to assist where needed.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of the resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant HCA or RN including designation.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The service screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the general manager and nurse manager. The admission agreement form in use aligns with the requirements of the ARRC contract. Written information on the service philosophy and practices particular to dementia care, (including minimisation of restraint, behaviour management and the complaints policy) are included in the information pack.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs, using the yellow envelope system (containing the resident's current clinical information) from residential care to the DHB acute hospital. Relatives are notified if transfers occur.
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	Twenty medication files were sampled (eight rest home, eight hospital, and four dementia level of care). The service uses an electronic medication management system. The medication management policies comply with medication legislation and guidelines. All required medication checks had been completed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication rooms. Medication administration practice complies with the medication management policy for the medication rounds sighted. Registered nurses and ENs administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. Two RNs reconcile the delivery of new medication and document this. There was evidence of three monthly reviews by the GP. All residents self-administering their own medication had completed the required competency assessments. Standing orders are not used.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All food is cooked on-site and the head cook oversees all functions and provision of food. Three cooks and two kitchenhands provide cover seven days a week. The head cook and kitchen staff stated that all staff have been trained in safe food handling. The service has a large workable kitchen. The kitchen and the equipment are well maintained. Meals are plated in the kitchen and delivered straight to the main dining area and via hot boxes to the four wings. A tray service is available and delivered via a hot box system to maintain correct food temperatures. The four-weekly seasonal menu is varied and developed by a dietitian (last review completed July 2017). Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed. At interview, the head cook described that the RN completes each resident`s nutritional profile on admission with the aid of the resident and family. Special diets are catered for and documented in the kitchen. Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented. The service encourages residents to express their likes and dislikes. The residents interviewed spoke highly about meals provided and they all stated that staff ask them about their food preferences. Equipment is available on an 'as needed' basis. Residents requiring extra support to eat and drink are assisted, this was observed during lunch. Fridge/freezer, end cooked and dishwasher temperatures are monitored. Food in the fridge and chiller were covered and dated. The kitchen is clean and all food is stored off the floor. Chemicals are locked away. Material safety datasheets are available. Food audits are carried out as per the yearly audit schedule.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service records the reasons for declining service entry should this occur and communicates this decision to potential residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs,	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six-monthly or when there was a change to a

support requirements, and preferences are gathered and recorded in a timely manner.		resident's health condition. The interRAI assessment tool is implemented and all residents have a completed interRAI assessment in their clinical file. Care plans sampled were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. One YPD resident had an activity plan that specified individual goals, one of which was to garden. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and HCAs follow the care plan and report progress against the care plan each shift at handover (witnessed). If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the hospice nurses or the older person's mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Current wound assessment, monitoring and wound management plans were reviewed. Documentation for pressure injuries was fully completed including ongoing evaluation/progress. The RNs have access to specialist nursing wound care management advice through the district health board wound care specialist. Interviews with RNs and HCAs demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	Switzer Residential has two full time (32 hours per week) diversional therapists (DTs) working Monday to Friday. An activities coordinator works across the weekends and afternoons. There is a large core of volunteers (at least thirty) who assist with some activities. There are two activities programmes (main hospital rest home area and dementia care area). Weekly calendars are displayed throughout the facility. All staff interviewed said the 'Eden Alternative' underpins the positive culture at Switzer Residential Care. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge areas. All recreation/activities assessments and reviews are up-to-date. Residents have a comprehensive assessment completed over the first few weeks after

requirements are appropriate to their needs, age, culture, and the setting of the service.		admission, obtaining a complete history of past and present interests (domain of wellbeing assessment is completed), career and family. The diversional therapists interviewed stated that they participate in six-monthly multidisciplinary meetings. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include entertainers, crafts, exercise, singing groups and movies. There are weekly van outings to community sites of interest (includes shopping trips, café stops, visiting restaurants for lunch). There are strong links forged with the community where community groups and individuals now invite themselves in to either participate in or provide activities. Local schools and kindergartens visit. One YPD resident interviewed stated they are excited to run a garden club and she looks forward to each new season. The club worked on a project to raise funds for a new garden area for residents to grow vegetables in raised beds. There is an 'ALZ Club' (day care) where people from the community visit for the day. There is an 'arts and crafts fair' organised by a resident who utilises 'discussion groups' as a way for residents with like-minded interests to get together and work on activities of their choice. One group knits for children in London, they make 'fish and chip' jerseys to wrap the babies in, one group focuses on art. Residents are encouraged to continue with their existing interests with some attending their individual interest groups in the community. Kuia and Kaumātua group visit regularly and involve Māori residents in cultural activities and some residents go out to local schools and participate in activities. There are now a number of animals residing at Switzer Residential Care, which residents interviewed stated they enjoy. Family members (two hospital and one rest home) interviewed, stated that activities are appropriate and varied enough for the residents. All ten (five rest home including one YPD and five hospital) residents interviewed stated they were happy with the activities available and were supported and are given a choice regarding attendance.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The RNs evaluate all initial care plans within three weeks of admission. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. Since 1 July 2015, reassessments have been completed using interRAI (LTCF) for all residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has implemented policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents and forms are completed by staff. There are no incident/accident reports reviewed involving waste, infectious material, body substances or hazardous substances. There is an emergency plan to respond to significant waste or hazardous substance management. All chemicals sighted were appropriately stored in locked areas. Chemicals are appropriately labelled. Sufficient gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires in June 2018. Reactive and preventative maintenance is documented and implemented. Fire equipment checks are conducted by an external fire safety contractor. When an issue requiring maintenance is noticed, the facilities manager deals with the issue on the same day. The facilities manager is available from Monday to Friday. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly and these are maintained at (or just below) 45 degrees Celsius. When temperatures were observed to be outside acceptable range, corrective actions were initiated and corrected. Electrical testing and tagging had been completed February 2017. Medical equipment had been tested February 2017. The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. There is sufficient space to allow residents to move around the facility freely. The hallways have hand rails and are wide

		enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The large lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have the residents' own personal belongings displayed. External areas and garden areas surrounding the facility are well maintained. Level paths to the outside areas provide safe access for residents and visitors. Pathways are clear and well maintained. Dementia residents had access to a secure internal garden area.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are five wings. All bedrooms in Kauri (rest home) have hand basins with the exception of one which has an ensuite. Matai (dual- purpose) eight have ensuites, six have separate toilets and hand basins, and three have hand basins. Millie (dual-purpose), 13 have ensuites and three have hand basins. Matai wing has eight bedrooms that have over the bed electric hoists. There are adequate communal toilets/showers available. Each bathroom has a hand basin and communal toilets have hand washing and drying facilities. There are soap dispensers in all bathrooms. There are separate staff/visitors' toilets. There is signage to promote effective hand washing techniques in the staff and visitors' toilet. There are hand sanitiser pumps available throughout the facility. The facility was clean, well presented and odour free. Ten residents interviewed report their privacy is maintained at all times.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate space in all resident rooms for residents, staff and equipment. Health care assistants confirmed they could move freely to provide cares and there is enough space to move mobility equipment safely. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley and bed access. Ten residents interviewed stated they are happy with their rooms.
Standard 1.4.5: Communal Areas For	FA	There is a spacious main lounge and dining area in all hospital and rest home areas. There is a large open plan lounge/dining area in the dementia care wing. The dementia wing has a kitchen available where the DTs do some

Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		baking with residents and families. There are smaller lounge areas within the facility. Residents were seen to be moving freely throughout the facility. Residents can move freely from their bedrooms to communal rooms and the outside. Internal and external doorways are level with pavements, which allows wheelchair access. The lounges and dining rooms are accessible and accommodate the equipment required for the residents and include places where young persons can find privacy within communal spaces. Activities occur in the main lounges and residents can access their rooms for privacy when required. Seating and space is arranged to allow both individual and group activities to occur. Diversional therapists have completed food safety training. One YPD resident likes to barbeque in the summer. Residents stated that they are happy with the layout of the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are cleaning policies and processes. There are sluice rooms in each wing for the disposal of soiled water or waste. On the day of the audit, these were locked when unattended. There are two full time cleaners covering seven days a week. Both have completed level two national qualifications in cleaning and caretaking. Cleaning trolleys are well equipped and stored in locked cleaners' cupboards. Cleaning schedules are maintained. There is a large well-equipped laundry with designated clean and dirty rooms. There is a laundry manager employed full time. Three part-time dedicated laundry staff provide support and cover across seven days per week. Cleaners and the laundry staff have attended chemical safety training. Material safety datasheets are available. Personal protective equipment is available in the laundry, cleaning and sluice rooms. Staff were observed to be wearing appropriate protective wear. Ten residents interviewed are happy with the cleaning and laundry services provided.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation plan, letter dated 27 July 2015. Fire evacuations are held six-monthly and the last drill was completed 8 August 2017. There is staff across 24/7 with a current first aid certificate. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, a large generator and a bore for water that is purified on-site. There are gas hobs in the kitchen and a BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. Oxygen cylinders are available. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells and residents interviewed stated their bells were overall answered in a timely manner. A test of a resident call bell demonstrated an appropriate response time. There are emergency management plans in place to ensure health, civil defence and other emergencies are

		included.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility has adequate heating throughout communal areas and corridors. Solar roof panels provide heating for the dementia wing. All bedrooms have heated wall panels. There is underfloor heating in Puriri (dementia) and Millie (dual-purpose) wings. All communal rooms and bedrooms are well ventilated and light. All bedrooms and communal areas have at least one external window. The indoor temperatures were pleasant and warm. Ten residents interviewed stated the temperature of the facility is comfortable at all times.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. There is a job description for the infection control nurse and clearly defined guidelines. The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually by the infection control committee. The facility has access to professional advice from Bug Control and has developed close links with the GPs, Community Lab, the infection control team, microbiologist and public health departments at the local DHB. There is a monthly Health and Safety (H&S) meeting with an IC component and QA meetings which include a discussion and reporting of infection control matters. Managers attend quarterly benchmarking meetings with five other retirement villages in Northland. Infection control issues are also reported at quarterly board meetings. Minutes for H&S meetings are available for staff. Audits have been conducted and include hand hygiene and infection control practices. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices.
Standard 3.2: Implementing the infection control programme	FA	The RN is the infection control (IC) nurse and is aware of the need to analyse data and the reasons behind this. The IC nurse receives ongoing education and completed online infection control training July 2017. She is a member of a NZ professional nursing body. In the event of the IC nurse requiring advice this is available through the GP, the DHB resource person or Bug Control.

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate. External expertise can be accessed as required, to assist in the development of policies and procedures. Policy development involves the infection control nurse and the infection control (health & safety) committee.
Standard 3.4: Education The organisation provides relevant education on infection control to all	FA	The IC nurse ensures training is provided to staff. Informal education is also provided - availability of education was confirmed by HCAs interviewed. The orientation package and ongoing bi-annual training includes specific training around hand washing and standard precautions. Training on infection control has been provided in 2017. Hand washing is an annual competency. Resident education is expected to occur as part of providing daily cares and there is a resident's infection control handbook that provides clear appropriate information about hand hygiene and cross infection.

service providers, support staff, and consumers.		
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	There is a policy that outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control nurse. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the health and safety and QA meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. The results are subsequently included in the general manager's report on quality indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. The infection control nurse reported a norovirus outbreak in March 2017 that affected thirty-three residents (three confirmed cases) and seven staff, appropriate notifications were seen to have been made.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes	FA	Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three-monthly and presented at the health & safety and infection control committee, then to the QA meeting.

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Five restraint/enabler files were reviewed, the files sampled identified that a restraint assessment, discussion with family/whānau and consent form were completed for the four residents requiring restraint and an enabler assessment and consent form is completed for the one resident requiring an enabler whose files were sampled. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan, evidenced in the five resident's file reviewed. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The files reviewed of residents requiring restraint have been evaluated three-monthly. Family/whānau participates in evaluations and at the residents' contract and care review meeting. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). Restraint practices are reviewed on a formal basis in the staff meetings and health & safety and infection control committee. A restraint evaluation is completed of the restraint care plan three-monthly. Evaluation timeframes are determined by risk levels. Family/whānau is involved in review at residents' contract and care review meeting.
Standard 2.2.5: Restraint Monitoring	FA	Approved restraint for each individual is reviewed at least three-monthly by the restraint coordinator and as part of the annual contract and care review meeting with family/whānau involvement. Restraint usage across the facility is

and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.		monitored monthly and advised that it is discussed at monthly staff and health & safety and infection control committee (and then to the QA meeting). An annual quality review of restraint usage is completed by the general manager. An internal audit for restraint usage was done in February 2017.

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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Switzer residential continually strives to improve services provided to residents and families. This is demonstrated through the introduction of the Eden Alternative and proactive empowerment of residents.	In 2014 the general manager and board of directors wanted to improve on the care model and change the culture of care to a person-centred approach. Representatives from Switzer Residential Care attended a three-day workshop on the Eden Alternative philosophy. Following this, a process of training all staff in the philosophy was commenced; currently thirty-two staff have attended the three-day training session becoming ‘Eden associates’. The general manager interviewed, stated “there is a positive feel about the home, the volunteer base has increased significantly with thirty plus volunteers now supporting the residents”. She states “volunteers are essential to the ongoing success of the project, they add spontaneity and variety and enable more individual, one-on-one interactions to occur. The community input has very definitely increased with the community now enquiring themselves to offer new and meaningful activities and companionship for residents”. Switzer Residential Care now has more animals (birds, fish and cats)

			residing at the home, many of the local school children/young people visit on a regular basis, Kuia and Kaumātua visit and involve residents in cultural activities and many of the local church groups visit. New initiatives have also been introduced to aid the resident and improve satisfaction. Learning circles are used consistently at Eden meetings and training at residents' association meetings and health and safety meetings. The 'domains of life wellbeing assessment' has been added to the admission process to identify specific resident history, interests and needs. A specific 'Eden support plan' has been introduced to address the three plagues of loneliness, helplessness and boredom. The service has noted an improved engagement of staff with resident. Healthcare assistants and diversional therapists on the day of audit were committed to the philosophy during interview. The 2016 surveys documented 73% (18% above benchmark) very good or good overall care satisfaction, following the initial implementation. Resident engagement has improved.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Switzer Residential Care is proactive in developing and implementing quality improvement initiatives. There is an established quality improvement programme that includes performance monitoring against clinical indicators. Quality improvement plans are developed where results do not meet expectations. There is a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Switzer Residential Care is part of the Far North Quality and Benchmarking Group that is made-up of five residential facilities within the region. Benchmarking is undertaken as part of the Far North Quality & Benchmarking Group. The group meets three-monthly. "First do no harm" benchmarking through the Northland DHB around pressure injuries and falls.	Switzer Residential Care is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data, the general manager and nurse manager discuss the data at the monthly QA meetings and any identified trends or issues. Any identified common themes around incidents/infections etc. results in further education. There is continued falls prevention education for all staff and falls data analysis is discussed monthly and available for all staff to view. Switzer Residential Care introduced a falls prevention programme in June 2013 with the objective to reduce falls by 12.5% and which focused on identifying strategies for the reduction of resident falls. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included residents identified as high falls-risk and the use of hi/lo beds, assessment and exercises by the physiotherapist (interviewed) and sensor mats. In May 2017, the service introduced a new call bell paging system throughout the facility with an average answering time for call bells from 6 minutes to 2.5 minutes in May and June 2017. Documentation reviewed identified that strategies were regularly evaluated. The outcome achieved was that the total of

			resident falls with injury for 1 October 2016 was at 10.22 falls per 1000 bed days, the total of falls reduced to 3.13 falls per 1000 bed days in June 2017. There has also been a reduction in falls with injury from November 2014 to November 2016 by 25%. The total of resident falls without injury for 1 October 2016 was at 5.83 falls per 1000 bed days, the total of falls reduced to 0.78 falls per 1000 bed days in June 2017.

End of the report.