North Waikato Care of the Aged Trust Board - Kimikia Home & Hospital

Introduction

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

The audit has been conducted by 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:	North Waikato Care of the Aged Trust Board
Premises audited:	Kimihia Home & Hospital
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: 30 November 2017 End date: 1 December 2017
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:	76

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

Kimihia Home and Hospital provides rest home and hospital level care, respite care and convalescent care for up to 77 residents. The service is operated by The North Waikato Care of the Aged Trust Board Incorporated which was formed in 1972. The facility is a community trust. There are 12 board members. The day to day services are managed by a facility manager who is supported by two clinical nurse managers. All three members of the management team are registered nurses. There has been a change in management structure and facility manager since the previous audit which was notified to the Ministry of Health. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, the contracted physiotherapist, gerontology nurse specialist from Waikato DHB, a community mental health nurse from the Mental Health Services for Older Persons and a general practitioner.

This audit has resulted in a continuous improvement in relation to the service delivery team approach and identified three areas requiring improvement relating to sharing of quality data results, human resources and monitoring of fridges.

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.

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

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

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

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

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 systems include collection and analysis of quality improvement data, 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.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment and medical equipment is tested at least annually or as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers and eight restraints are in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	3	0	0	0
Criteria	1	97	0	3	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	Kimihia Home and Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form and evidenced in all resident's files reviewed. Where a resident is deemed incompetent to make an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The facility manager provided examples of the involvement 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	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns 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 knew how to do so. Complaints forms are located around several areas of the facility and are accessible to residents and visitors. The complaints register reviewed showed that 12 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There were no open complaints at the time of audit. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer areas together with information on advocacy services, how to make a complaint and feedback forms.

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	Residents and their families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room, or share a room with another person/s with their consent. Residents are encouraged to maintain their independence by community activities, arranging their own visits to the doctor, participation in clubs of their choosing and going out with family on a daily basis. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
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	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. The residents and whanau were unavailable at the time of audit for interview, however documentation in the residents' files showed good communication demonstrating that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion,	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All

harassment, sexual, financial, or other exploitation.		registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. Language and communication needs and use of alternative information and communication methods are available and used to support 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	The overall governance of the facility is managed by a board of trustees consisting of 12 members who are from a general mix of local community services. The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed adequate information to monitor performance is reported including new providers, staffing, quality data results, financial performance, emerging risks and issues. An interview with the board chairman confirmed there is excellent communication between the facility manager and the board and that he visits the facility at least once a week so that he is fully aware of any issues or concerns. A change of Trustees was notified to the Ministry of Health in September 2017.

		The care facility service is managed by a facility manager who is a registered nurse and who holds relevant qualifications. They have been in the role for eight months but have worked at the facility prior to this, firstly, as a registered nurse in 2008, then from 2011 as a clinical nurse manager. Change of management was notified to the Ministry of Health (MOH) in April 2017. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at professional forums run by the New Zealand Nurses' Organisation, gerontology workshops at WDHB, completion of human resources studies and participates in the WDHB Professional Development and Recognition Programme, including related education. She is supported by two clinical nurse managers who are both registered nurses, an accounts manager and the household services supervisor. The service holds contracts with Waikato District Health Board (WDHB) for respite, convalescent care (medical), rest home care and hospital level care and the Ministry of Health (MOH) for residents under 65 years. At the time of audit there were 76 residents, 72 residents were receiving services under the Age Related Residential Care contract; 10 secure dementia care, 24 hospital level and 38 rest home level care. (WDBH contract). Two rest home level care residents were under the Residential Respite Contract (WDHB). One hospital level care resident was receiving services under the Residential Non-Aged Contract (MOH). One hospital level care and one rest home level care resident received services under the WDHB Convalescent Care Contract. (This contract is funded from WDHB Person-centred Acute Community Care (PACC) funding).
Standard 1.2.2: Service Management 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.	FA	When the facility manager is absent, the senior CNM and accounts manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by one of the CNMs. Both are experienced in the sector and able to take responsibility for any clinical issues that may arise. If both CNMs were to be away, the clinical oversight would be undertaken by the facility manager. Staff reported the current arrangements work well.

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.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, clinical incidents including infections and 'wandering', medication errors, challenging behaviour, pressure injuries and wounds. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting health and safety meetings, and board meetings. Reports of completed data are available to all staff, but there is no evidence to show they are discussed at staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and corrective action implementation. Relevant corrective actions are developed and implemented to address any shortfalls. One quality initiative is the use of a 'Dementia resident surveillance form' which identifies for each resident the type of dementia, challenges identified, the frequency of any challenging behaviour and pattern of occurrence and the management strategies to de-escalate a situation. (Refer comment in criterion 1.3.3.4). The quality data is compared to other on-site data and benchmarked against eight other like facilities who belong to the Community Trusts in Care Aotearoa (CTCA) group. Resident and family satisfaction surveys are completed annually. The most recent survey in March 2017, showed questions were raised around food services, laundry and activity diversity. The facility manager, CNMs and staff confirmed these were followed up and actions were taken to rectify the issues. Not all corrective actions were clearly documented and although staff can verbalise the positive outcomes, this evaluation is not documented. (Refer comments in criterion 1.2.3.6.) No negative comments were made by any person interviewed at the time of audit. 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. All policies and procedures sighted were current. The health and safety champion and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The monthly health and safety committee meet monthly as part of the RN meeting. The information presented monthly to the board allows achievement against the quality and risk management plan to be measured.

Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the RN meeting and reviewed by the health and safety committee. This information is included in the report presented to the board by the facility manager monthly. The facility manager and CNMs described essential notification reporting requirements, including for pressure injuries. They advised the only significant event has been reported using Section 31 reporting made to the Ministry of Health related to aggressive behaviour of a resident in November 2016. The police were involved to assist as required. There have been no police investigations, coroner's inquests, issues based audits and any other notifications, such as to public health.
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.	PA Low	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are not being consistently implemented, not all files contained completed staff orientation records, and annual appraisals are not all up to date. Orientation records sighted that were completed, included all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. At the time of audit, 19 caregivers have completed a NZQA level four qualification, plus the enrolled nurse and two diversional therapists, four caregivers have completed level three plus the rehabilitation assistant, two caregivers have completed level two and 15 caregivers have commenced NZQA papers and are at various stages of completion. All household staff who work in the kitchen hold NZQA standard 167 and safe food handling certificates. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Seven RNs have completed their professional development and recognition programme (PDRP) requirements with WDHB with appropriate endorsements sighted for two staff. Three recently employed RNs have yet to commence the PDRP process.

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). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. The facility manager and two CNMs share on call duties. 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 four weeks' rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital. The service uses interRAI information in relation to supporting staffing decisions related to residents' needs and acuity. Dedicated staff work in the dementia care secure unit for all shifts. There are seven household staff who work eight hour shifts to cover the kitchen, cleaning and distribution of linen, seven days a week. Two diversional therapists work Monday to Friday 72 hours per week, plus an activities assistant eight hours per week. A contracted physiotherapist works six to eight hours per week and a rehabilitation assistant works Monday to Friday 40 hours per week. Reception is staffed Monday to Friday 40 hours per week and an accounts administration works 30 hours per week. The administration person, CNMs, and accounts manager work Monday to Friday 40 hours per week, and the facility manager works Monday to Friday 37.5 hours per week.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Disability Support Link Assessment and Service Coordination (DSL) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided

facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		with written information about the service and the admission process. The organisation seeks updated information from DSL and the GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements which included EPOA consent and acknowledgement for residents whom have a cognitive impairment. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation and communication between all parties. Family of the resident reported being kept well informed during the transfer of their relative.
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 a paper based 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 RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly, the last controlled drug audit was completed in August of 2017 and recommendations made at that time have been implemented. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for four medicine fridges and the two medication rooms reviewed were within the recommended range.

		Good prescribing practices noted include 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 is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines. There are four residents who self-administer medications. All four residents at the time of audit did not have medication stored securely in their bedrooms. By the end of the audit, three residents' medications were secured, and one resident's medication was returned to the medication room. Up to date documentation of competence was sighted for all four residents self-administering medications 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 service delivery.	PA Low	The food service is provided on site by two qualified cooks, household staff, and a dedicated kitchen team, overseen by a household supervisor, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was last reviewed by a qualified dietitian in April of 2016 with an 'excellent rating'. Aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines however there is a total of twelve food fridges within the facility that are not being regularly monitored. The service is currently developing an approved food safety plan and is aware of the deadline date of March 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The household supervisor and kitchen staff have undertaken safe food handling qualifications. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the DSL is made and a new placement found, in

is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale as a means to identify any deficits and to inform care planning when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Resident files reviewed for behaviour management plans including triggers and interventions for behaviours. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
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 verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. The clinical nurse specialist for gerontology and community mental health nurse for mental health services for older people were also interviewed and stated that the communication is good and care is also provided to a high level. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the	FA	The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy and an activities assistant.

service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six- monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, such as music and one to one interaction.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health services for older persons and the dietician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of	FA	Staff follow documented processes for the management of waste and infectious and hazardous

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.		substances. Appropriate signage is displayed where necessary. Housekeeping staff have all completed safe chemical handling training within the past year. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored. Staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.
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 (expiry date 31 March 2018) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (tested in August and September 2017) and calibration of bio medical equipment (tested February 2017) was current as confirmed in documentation reviewed. The service has appropriate equipment to manage residents of all levels of care which includes oximeter, oxygen concentrators and regulators, suction, electric beds, sit on weigh scales, two bedrooms with ceiling hoists and four mobile hoists. Maintenance is undertaken on a contracted basis. Observation of the environment confirms the facility is maintained to an appropriate standard. Staff confirmed they know the processes they should follow if any repairs or maintenance is required. Documentation identifies requests are appropriately actioned in a timely manner. This was supported by residents and families interviewed. The environment was hazard free, residents were safe and independence was promoted. There are dedicated storage areas for equipment. Monthly environmental audits are conducted and findings reviewed by the health and safety champion who reports all actions to the registered nurse meeting and the board. External areas are safely maintained and are appropriate to the resident groups and setting. The secure dementia care area has an easily accessible outdoor area, with shade, seating, fruit trees and winding paths.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes thirteen bedrooms with full ensuite facilities and separate staff and visitor toilet areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
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	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms with four beds in each room. Permission is always gained from the resident or the EPOA prior to accepting a resident into one of these rooms. Each bed has a call bell, curtains that provide visual privacy and an attached conservatory area at one end which allow safe storage of chairs when they are not in use. This area can be used for residents during the day if they choose. All other bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. The dementia area has a dining and lounge area which are also used for activities. In the open care unit there are three lounge areas, three dining areas, a chapel, a physiotherapy rehabilitation room, and a large lounge which is also used for activities, such as bingo as tables and chairs that can be set up for this. The diversional therapists' room is located at one end of this lounge area. The dining and lounge areas are spacious and enable easy access for residents and staff. There are also small seating areas where residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. There is also a dedicated doctors' room used for consultations and family meetings as required.
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	Laundry is contracted to an off-site provider. However, facilities allow residents to do their own personal washing if they wish and short stay respite residents' personal washing is done onsite. All long-term residents' clothing is microchipped and clearly labelled. This is a quality improvement which has been implemented since the previous audit. Each resident's clothing is returned to the facility in individually packed plastic bags which are clearly labelled to say who the clothing belongs too. Housekeeping staff deliver the residents' clothing to their bedrooms. When the laundry service was contracted off-site, some personal clothing was damaged as identified in the complaints log sighted. The service replaced

		damaged clothing and have taken actions to prevent this re-occurring. Both care staff and housekeeping staff demonstrated a sound knowledge of the laundry processes, clean flow of laundry returned and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The housekeeping team which consists of cooks, cleaners and laundry staff, have received appropriate training. Most members of the housekeeping team can work in all three areas. All staff have undertaken appropriate New Zealand Qualifications in safe food handling and have annual safe chemical handling education as was sighted in education files reviewed. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and visual checks undertaken by the housekeeping supervisor.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides are used to direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 08 November 2012. A trial evacuation takes place six-monthly by an approved contracted provider; the most recent being on 22 May 2017 with no follow up required. There next fire evacuation is booked for the week following audit as confirmed in emails sighted. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Staff attendance at fire and emergency training is compulsory and this is overseen by one of the CNMs. Actions are taken to remind staff if they have not met this requirement. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 77 residents. Water storage tanks are located in the grounds of the complex with bottled drinking water stored indoors. There is a diesel generator on site which lasts up to 48 hours. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. All areas have a call bell system which residents and families reported staff respond to promptly. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. This is confirmed in documentation sighted. A 'wander guard' system is in place so that staff can be alerted if residents who tend to wander go past a certain point. This is only used with the consent of the resident's EPOA as identified in residents' files reviewed.

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	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and two bedrooms have doors that open onto outside garden. Heating is provided by gas heated water radiators in residents' rooms in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
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 service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from clinical nurse specialists as required. The infection control programme and manual are reviewed annually. The clinical coordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, tabled at the health and safety committee meeting and a report is provided to the board. This committee includes the facility manager, IPC coordinator, the health and safety officer, and representatives from food services and household management. Signage is not evident at the main entrance to the facility, however staff requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for eight months. She has undertaken a certificate in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.

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 prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
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, eye, and respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, 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 via regular registered staff meetings, however this information is not extended to caregivers' meetings (please see criterion 1.2.3.6). This information is sighted in the staff room for staff to view. Graphs are produced that identify trends for the current year and comparisons against previous years, and this is reported to the facility manager. Data is benchmarked externally with other aged care providers. Benchmarking has

		provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, eight residents were using restraints (all in the open care unit, not used in dementia) and two residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes (RN meeting), files reviewed, and from interviews with staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group, made up of the registered nurses, is led by the restraint coordinator who is one of the CNMs. The restraint coordinator, RNs and GP are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The CNM interviewed/restraint coordinator described the documented process which was confirmed in residents' files reviewed. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a

		restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised. The restraint coordinator described how alternatives to restraints are discussed with staff and family members such as the use of sensor mats, low beds and de-escalation. The restraint register and meeting minutes identifies restraints that have been commenced and those that have ceased. Once a resident has restraint stopped they are put onto a short term care plan for close monitoring until the restraint committee agree this was a safe decision to make. Short term care plans are also put in place when a resident first commences on restraint to ensure all staff are aware of this and the required monitoring times. If after one month it is agreed that the restraint is safe for the resident the short term care plan ceases and the monitoring is undertaken according to assessment requirements. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation being completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported at RN meetings. Minutes of meeting reviewed confirmed this includes

Services demonstrate the monitoring and quality review of their use of restraint.		analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with staff and management confirmed that the use of restraint has been reduced by two over the past six months.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is collected and analysed monthly at senior management level. Corrective actions are put in place and management and staff can verbalise the outcomes. This can also be seen in data results, such as skin tears being reduced from 28 in April 2017 to 10 in September 2017; however, evaluation of corrective actions is not well documented. Quality data results are posted on a board in the staff room which all staff have access to, but they are not reported at staff meetings.	Quality data findings are not discussed at staff meetings and there is limited documented evaluation of findings.	Ensure all quality data corrective action outcomes are evaluated and that all quality data is shared with all service providers. 180 days
Criterion 1.2.7.4 New service	PA Low	Staff confirmed that they receive an in-depth orientation which covers the essential components of the service provided, including emergency management, policies and procedures, infection control and health and	Not all staff orientations information could be	Provide evidence that staff have

providers receive an orientation/induction programme that covers the essential components of the service provided.		safety. However, of ten staff files reviewed, only three contained completed orientation records. It was also noted that senior management staff appraisals have not been undertaken for 2017. The service has a programme in place to ensure these are to be completed within the year.	located in the staff files reviewed. Not all staff annual appraisals are up to date.	completed an orientation and that annual appraisals are kept up to date to meet contractual requirement D17.7 f. 180 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The facility has a very low infection rate. There is a total of twelve food fridges within the facility (11 studio, two rest home residents with fridges in their rooms and three remaining kitchenette fridges in three communal areas of the facility). At the time of audit these fridges were not monitored, or temperatures checked and recorded, despite the fridges not being monitored, there was no indication that the fridges were not being managed safely. A register was developed by the end of the audit. The facility manager stated that the temperatures monitoring and recording of the fridges would be commenced the following day.	There is no documented evidence that the cleaning schedule in the kitchen is being implemented. Temperatures and contents of 12 (twelve) resident fridges are not being monitored.	Provide evidence that resident's fridges are monitored to comply with safe food hygiene and correct temperatures are maintained. 60 days

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 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where	CI	Kimihia Home and Hospital has created a ‘paper round’ which occurs monthly and is an extension and more in-depth review of a resident than would normally occur at a multidisciplinary meeting. A team approach occurs and includes the facility manager, clinical nurse manager, diversional therapist, physiotherapist, rehabilitation assistant, GP and Nurse Practitioner for Gerontology. Other health care professionals from different areas are also invited to attend. A client centred approach occurs, and all aspects related to the resident’s care and issues arising are discussed. There is an emphasis to trial and provide non-pharmacological interventions based on evidence and information collated by staff. Care plans are updated, reviewed and evaluated. Care staff interviewed stated that any changes to care and outcomes are discussed in handover. Residents and families interviewed stated that they are included in this assessment approach and are very satisfied with both the care that is provided and the attention to detail.	Kimihia Home and Hospital has achieved a continuous improvement in development of the ‘paper round’. There are clearly documented findings and evidence of actions taken based on the findings. The improvements made to the service provision and resident safety or satisfaction is measurable. This was supported during staff, resident and family interviews and in the resident satisfaction survey results sighted gaining an overall higher satisfaction result for overall care services. All benefits gained, and outcomes achieved have either a resident safety or satisfaction component.

appropriate.			

End of the report.