Auckland Presbyterian Hospital Trustees Incorporated - St Andrew's Village

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:	Auckland Presbyterian Hospital Trustees Incorporated
Premises audited:	St Andrew's Village
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: 22 November 2017 End date: 23 November 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: 170

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

St Andrews is an independent Charitable Trust. The service provides care for up to 190 residents (10 beds are currently decommissioned for refurbishment) with 170 residents on day of audit. The service is certified to provide hospital (geriatric and medical), rest home and dementia level care.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioners.

The organisation is governed by a Board of Trustees. Business planning is undertaken at executive level with input from all levels of staff across the organisation.

There is an on-site management team with various roles across the village who support an experienced CEO. There are two clinical managers (CMs) who are responsible for the day-to-day management and clinical oversight of the Houses. The clinical managers oversee five nurse managers across the seven houses.

There are quality systems and processes being implemented that are structured to provide appropriate quality care. Quality initiatives are being implemented which provide evidence of improved services for residents. There is an orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support. Residents and relatives interviewed all spoke positively about the care and support provided.

The facility has embedded the interRAI assessment protocols within its current documentation. All care plans reviewed were individualised and comprehensively completed. 'At risk' residents have been identified and monitoring strategies were being implemented and regularly evaluated.

The service is commended for achieving continuous improvement ratings relating to good practice, quality improvements, H&S programme, training programme, activities programme, emergency preparedness and restraint minimisation.

One improvement has been identified around hot water temperatures.

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.

St Andrews endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of annual reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes.

St Andrews is implementing the organisational 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 quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place and monitored with high attendance. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

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

The service has admission policies and procedures. There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses/develops care plans and reviews each resident's needs, outcomes and goals at least six monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

There are policies and procedures for medicine management. Registered nurses are responsible for the administration of medicines and complete annual medication competencies and education. The medicines records reviewed include photo of allergies and sensitivities. The GP reviews the medication records three monthly.

The activities programme is facilitated by an activities team. Each resident has an individualised activity plan, which is reviewed at the same time as the clinical care plan. The activities programme provides varied options and activities that meet the consumer group. Links with the community are maintained and van outings are arranged on a regular basis.

All food is cooked on-site. Residents' nutritional needs are identified and accommodated, with alternative choices provided. Meals are well presented and homely, and the menu plans have been reviewed by a dietitian. The cooks are qualified, and staff have undertaken food safety and hygiene training.

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.		Some standards applicable to this service partially attained and of low risk.

Chemicals are stored securely throughout the facility and there are documented processes for waste management. The building holds a current building warrant of fitness. The facility is made up of five houses and two lodges. The rest home (lodge) and Stirling dementia unit have toilet and basin ensuites with shared showering facilities. The remaining rooms throughout the facility have full shower and toilet ensuites. Communal areas within each house are easily accessed with appropriate seating. There are adequate external areas with seating and shading to accommodate the needs of the residents. External areas are safe and well maintained.

Cleaning and laundry services are well monitored through the internal auditing system. The organisation provides housekeeping and laundry policies and procedures which are robust and ensure all cleaning and laundry services are maintained and functional at all times. In Stirling dementia unit, there is a small 'home like' laundry where personal laundry is able to be completed.

St Andrews has a documented emergency and disaster plan in place as per the Health and Safety programme and an approved emergency evacuation plan signed off by the New Zealand Fire Service. Six monthly trial fire evacuations are conducted & civil defence processes are in place. Appropriate training, information and equipment for responding to emergencies is provided.

There are call bells and emergency bells in all resident rooms and communal areas. The system software is able to be monitored. Staff in Stirling Lodge wear call bell pendants to get assistance in an emergency. General living areas and resident rooms are appropriately heated and ventilated.

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

The restraint minimisation and safe practice policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. The restraint standards are being implemented and implementation is reviewed through meetings, and CQR (Clinical Quality and Risk) meetings. Interviews with the staff confirm their understanding of restraints and enablers. On the day of audit, there were four residents assessed as needing restraint for safety. There were seven residents with enablers in the form of bedrails.

Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. There has been a decline in restraint use overall (from over 20 restraints in 2015, down to 4 restraints in November 2017).

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking externally. Staff receive ongoing training in infection control.

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	4	45	0	1	0	0	0
Criteria	7	93	0	1	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. The Code is displayed in both Māori and English versions and the pamphlets and booklets are readily accessible. Staff receive training about the Code during their induction to the service, which continues through the mandatory in-service education and training programme. The service has an advocacy service which is readily available with support from two Chaplains on-site providing pastoral care/spirituality support where needed. The Health and Disability Advocacy Service pamphlets with relevant contact numbers are displayed at reception and in all service areas around the facility. Interviews with staff (14 clinical assistants [across all areas and shifts], seven registered nurses, clinical managers, and four activity coordinators), reflected their understanding of the key principles of the Code. Clinical assistants could describe how the Code is incorporated in their everyday delivery of care.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of	FA	There are established informed consent policies/procedures and advanced directives. General consents are obtained on admission and have been reviewed, approved and re-implemented. Specific consents are obtained for specific procedures such as influenza vaccine. Fourteen resident files (three rest home, seven hospital, four dementia) sampled contained signed general consents. Resuscitation status had been signed appropriately. A CPR treatment plan is available in the form of a flow chart

choice are provided with the information they need to make informed choices and give informed consent.		outlining staff responsibilities and management of resuscitation. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The clinical assistants interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Nine family and thirteen residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Fourteen resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility and in each house. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. 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	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they can participate in as much as they can safely and desire to do. The two clinical managers are available to families as well as the individual nurse managers for each care setting. Quarterly newsletters are developed and implemented, and all families receive a copy. Additional copies are available in all houses for residents. Family members and residents are invited to the six monthly multidisciplinary review meetings held for each resident. Family have input into the care planning and the activities programme to meet the needs of the individual resident concerned. Links are maintained with activities in the community being encouraged as part of the activities programme. Van outings into the community or attendance at church services at local churches is encouraged. Pastoral care services are available. School children and kindergarten children from the region often visit the facility and provide entertainment, which is well received by the residents. The end of year 2016 relative satisfaction survey resulted in an 83% satisfaction for the question “your involvement in the St Andrews community”, this was an improvement from 2015. The resident satisfaction survey was 72 %, which was also an improvement on the 2015 survey.
Standard 1.1.13: Complaints	FA	There is a comprehensive complaints and concerns policy. The complaints procedure is provided to residents and relatives on entry to the service. The service maintains a record of all complaints and concerns both verbal and written. They proactively manage all concerns and include these on the complaint register. Documentation

Management The right of the consumer to make a complaint is understood, respected, and upheld.		including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Interviews with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location around the facility. Staff interviewed could all describe the complaints procedure and feedback provided at all meetings including house meetings. Eleven complaints/concerns from 2017 (YTD) were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Complaints investigation reports were completed for the majority with corrective actions and recommendations. Resolution was also identified. Feedback is provided to staff and toolbox talks were completed where required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The admissions manager, clinical managers and nurse managers (at each house) discuss aspects of the Code with residents and their family on admission. Six monthly multidisciplinary meetings also allow time for residents and family to discuss any concerns including individualised care and choice. The management team provide an open-door policy, and this is reflected in interview by residents and relatives. All 13 residents (seven rest home level and six hospital level) and nine relatives (two hospital, seven dementia) interviewed, reported that the residents' rights are being upheld by the service. Interviews with staff also confirmed their understanding of the Code and its application to aged residential care.
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 are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Dignity and privacy policy describes how dignity, privacy and autonomy is preserved at all times. The last satisfaction survey (end of 2016) identified 94% of residents were satisfied with privacy and 94% with being treated with dignity and respect. Interviews with residents and relatives identified consistent positive feedback about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. If a resident has specific spiritual/religious affiliations, this is identified on admission as part of the information gathered by the admissions manager for the "Front Sheet" of the resident's file. Spiritual needs are identified, and church services are held. The spiritual/cultural care plan is completed by the RNs as part of the holistic assessment and long-term care planning process, and members of the multi-disciplinary team including pastoral team, can contribute to this. There is a policy on abuse and neglect and staff receive annual training which is mandatory. All 14 clinical assistants interviewed had received education and had a good understanding of abuse and neglect and how to

		report any suspected incidences to the nurse managers in their respective service areas. The service has achieved Silver Rainbow certification status this year, with updating of policies and many staff attending training in gender diversity. Residents admitted to the two dementia units (Henry Campbell unit and Stirling Lodge unit) are assisted and supported to maintain as much independence as possible.
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	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There is one resident whom identifies as NZ Māori living at the facility. There is a comprehensive Māori Residents: cultural, values and care policy, which describes the expectations when providing care and services for residents who identify as Māori. Māori consultation is available through the documented Iwi links and local Māori ministers. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All clinical assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents. St Andrew's Village provides two yearly mandatory training for all staff with respect to cultural safety and this includes reference to Te Tiriti o Waitangi. There is Tikanga best practice guideline available to guide staff on how to deliver safe and effective services for Māori. Values and beliefs identified during the assessment process are taken into consideration and documented on the individual resident`s care plan. All care plans reviewed were individualised to the resident and their whānau's (family's) needs, preferences and wishes.
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	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. The 2016 satisfaction survey identified 91% positive outcome for cultural/spiritual needs being met. There is a multi-cultural staff employed at St Andrews and a number of residents from other cultures. Clinical assistants interviewed could describe learning about their residents and cultures. In one dementia unit, picture cards are being utilised for one resident that doesn't speak English. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

values, and beliefs.		St Andrew's provides a Pastoral Care team who are available to meet spiritual needs of all residents and their families, regardless of their religion or faith, or residents can be referred to other spiritual care providers if required or requested.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. Policy and procedures related to discrimination ensure residents receive services free from any discrimination, and that residents are not subjected to any form of coercion, harassment, sexual or other exploitation. Professional boundaries are defined in job descriptions. Interviews with clinical assistants and registered nurses confirmed their understanding of professional boundaries, including the boundaries within their roles and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Evidence-based practice is evident, promoting and encouraging good practice. There is an experienced clinical team that includes two clinical managers, five nurse managers across the eight houses. They are supported by a quality team and registered nursing staff. There are four house GPs that provide 28.7 hours on-site a week and on call as needed. The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on-site, five days per week with the support of four physiotherapy assistants. There is a regular in-service education and training programme for staff. In-service education attendance is monitored by the clinical training coordinator. The service has links with the local community and encourages residents to remain independent. Policies and procedures and information sheets are examples sighted of evidence-based practice and go through a quality process when developed, reviewed and prior to approval and implementation. All sources of information are referenced on the policies sighted. St Andrews has been proactive around implementing quality initiatives, these are established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness. The clinical quality improvements/outcomes are displayed on the staff noticeboards also for staff/residents/family to view in each service. Evidence-based practice is observed as documented, promoted and encouraged across all services by the CEO and quality management team.
Standard 1.1.9:	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		responsibility to notify family/next of kin of any accident/incident that occurs. Management interviewed described an open-door policy. Evidence of communication with family/whānau is documented and held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. A sample of thirty-one accident/incident forms reviewed across five houses (October 2017), all identified that family are kept informed. All relatives interviewed stated that they are kept well-informed when their family member's health status changes. A resident-centred approach to service delivery and open communication is respected by staff. A communication book is available in all services. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. 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 service has developed a number of information pamphlets for residents/relatives that are kept in each house. Examples include (but not limited to); pamphlets with the following titles; 'weight loss in advance, advanced dementia, medical services, visiting at St Andrews, taking residents out on day visits, preventing falls, managing an outbreak and you can help, what to expect when someone is dying and your care plan.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Andrews is an independent Charitable Trust, Not for Profit organisation. The village is large and situated across spacious grounds. The service provides care for up to 190 residents (10 beds are currently decommissioned for refurbishment) with 170 residents on day of audit. The service is certified to provide hospital (geriatric and medical), rest home and dementia level care. The service is resident-focussed with a vision and mission statement. The organisation has a mission, which is commitment to person-centred aged care, including dementia care. Care is provided across a number of smaller houses. There are seven houses across the grounds. All houses have been designed to provide a homely environment giving due consideration to the comfort and safety of the residents: (i) House one (Hector) includes a 30-bed hospital and rest home level care. Twenty of the beds are dual-purpose and there are two DHB respite funded beds. On the day of audit there were eight rest home (including one respite and one resident under a mental health contract) and 21 hospital residents. (ii) House two (Marion Ross) includes 30 hospital beds with full-occupancy. (iii) House three (Bruce) – includes 30 hospital level care beds (including three Orthopaedic Interim Care Programme beds [OICP). Occupancy was 29 hospital residents (including one on respite) and two residents on OICP funding; (iv) House four (Douglas) – provides hospital level care and has a specific palliative care wing (Dove wing) that has three DHB funded palliative care beds (run in conjunction with Eastern Bays, or Dove Hospice). Occupancy in the house was 27 of 30 residents including one resident (respite) in Dove wing; (v)

		House five (Henry Campbell) – included 25 residents across a 30-bed secure dementia unit; (vi) The lodges – is a 20-bed rest home with current occupancy of 20 residents. (vii) Stirling Lodge – (female only unit, opened August 2017) included nine residents across a 10-bed secure dementia unit. The service also holds a YPD contract, however there were no current residents under that contract. The organisation is governed by a Board of Trustees. Business planning is undertaken at executive level with input from all levels of staff across the organisation. The quality management framework clearly identifies the organisation's commitment to including all health care services, staffing and meeting the needs of residents and family/whānau. Both the business and quality plans are reviewed throughout each year to measure achievement. The organisation's goals and direction are clearly described and match the organisation's mission, vision, values and strategies put in place to assist all resident needs to be met. The organisation has an experienced management team and the Chief Executive Officer (CEO) reports monthly to the Board of Trustees (BOT) on all aspects of service delivery, inclusive of all quality projects, data, risk management and major improvements. The BOT ensures governance of all services. There are subcommittees for strategic planning, finance and risk, clinical governance and property. The monthly meetings ensure that the strategic direction is being maintained, they monitor the progress of business and quality key performance indicators via information from departmental reports received. The on-site management team is made up of the CEO; human resources manager/household manager, the 'quality, risk and audit' manager, the facilities manager, the accounts manager, admission's manager, and two clinical managers (CMs) who are responsible for the day-to-day management of clinical oversight. Both CMs hold current annual practising certificates, have worked previously in management positions in aged care and have completed education related to dementia care. The management team are supported by a team of coordinators. The clinical managers oversee five nurse managers across the seven houses. There are clear lines of accountabilities and organisational chart. There is an implemented quality and risk management system that is regularly reviewed and refined to further improve service delivery. The organisation completes annual planning and has comprehensive policies/procedures to provide rest home care, hospital (geriatric and medical) and dementia level care. The management team have all completed at least eight hours of training annually around management of a rest home/hospital.
Standard 1.2.2: Service Management The organisation ensures the day-to-day	FA	The HR manager undertakes the CEO role when required, to cover annual leave or sick leave. St Andrews Village undertakes succession planning to ensure cover for members of the executive/management team. The two clinical managers (RNs) provide clinical oversight for each other. Nurse managers in each area are

operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		supported by senior registered nurses. The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital (medical and geriatric) and dementia level care. Operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.
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.	CI	A quality and risk management programme is well established. Interviews with the quality risk & audit manager, clinical quality coordinator, nurse managers and staff from all six houses reflect their understanding of the quality and risk management system and how that is implemented across the village. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies for review or development are checked or written by the department expert, using reference to best practice, and then sent for consultation to the appropriate group. Policies are regularly reviewed. There is intranet for staff to be able to access policies. As policies and procedures are developed or reviewed, they are uploaded to the intranet and relevant staff are notified by email. Key components of the quality management system link to the monthly clinical and quality risk management committee through representatives from each department. Monthly reports from infection control and health & safety are provided to each house along with quality indicator reports and a variety of organisational meeting minutes (including quality and risk) provide a coordinated process between service level and organisational management. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure injuries, unintentional weight loss, and medication errors. An annual internal audit schedule including specific clinical-focused audits was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in a variety of meetings, and reports are forwarded to house meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Quality data reports are completed by the ‘data and information management technician’ monthly and further analysis is completed of those reports by the quality and risk audit manager. St Andrews reports, analysis and consequent corrective actions were sighted. Interviews with staff and review of meeting minutes/quality projects/summary reports, demonstrate a culture of quality improvements.

		Quality and risk data is shared with staff via meetings and by posting results on noticeboards in each house. An annual resident and relative satisfaction survey is completed. The December 2016 results demonstrated a 90% positive outcome from the Resident survey, and 97% from Relatives. Corrective actions were established in the lower ranking areas. The health and safety programme is monitored and overseen by the H&S committee. There is an appointed health and safety officer who is supported by health and safety representatives from each area. The health and safety team meet's monthly. The service has made a number of improvements to H&S since previous audit and following the update of H&S legislation including (but not limited to); updates on responsibilities and accountabilities for contractors, (iii) upskilling of executive team and board of trustees regarding responsibilities and accountabilities; and (iii) they completed a total re-write of the Health and Safety policy. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility. The hazard register is reviewed regularly. Actual and potential risks are identified and documented in the hazard register. They are communicated to staff and residents as appropriate. Hazards are reviewed by the Exec, H&S and CQR committees and any newly identified hazards that cannot be eliminated are added to the register. The risk register is also monitored by the CEO at least six monthly. Staff confirm during interview that they understand and implement documented hazard identification processes. Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), physiotherapy and physiotherapy assistants input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Clinical assistants interviewed confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.
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	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Corrective actions are clearly documented and signed off when completed. Shortfalls identified are used as an opportunity to improve service delivery and all information is shared with staff as confirmed in meeting minutes sighted. A sample of thirty-one accident/incident forms were reviewed across five of seven houses (October 2017). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Incidents are benchmarked and analysed for trends (link 1.2.3.6). All serious incidents logged are automatically escalated to the clinical manager and quality and risk audit manager (QRM) immediately. Actions are then followed up and managed. The outcome of corrective action planning is monitored, and an example sighted identifies that the number of serious harm events related to resident falls has been maintained below the aged care target 10 of the 12 months between October 2016 – October 2017. The geriatrician and two GPs meet with the senior clinical team quarterly to discuss clinical indicators. The service has a serious incident review panel which has set terms of reference including investigating and reporting on serious harm and ensuring sharing

		of learnings gained from the incident. Monthly clinical indicator reports provided to staff and interviews with staff (registered nurses and clinical assistants) demonstrated an understanding of the incident reporting system and links to the quality and risk management system. Interviews with the QRM and clinical managers confirmed awareness of their requirement to notify relevant authorities in relation to essential notifications.
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 in place, including recruitment, selection, orientation and staff training and development. Sixteen staff files (two nurse managers, four RNs, seven clinical assistants, chef, diversional therapist, maintenance person,) reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, training, competencies and annual performance appraisals. A register of practising certificates is maintained. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, clinical assistant) and includes documented competencies. New staff are buddied for a period of time (eg, clinical assistants, two weeks, RN four weeks), and during this period they do not carry a clinical load. The clinical assistants when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. A Careerforce assessor works with all new clinical assistants across three months to complete orientation. There are six Careerforce assessors at St Andrews and currently 95% of clinical assistants have a recognised qualification. There is a mandatory training programme in place. Training is repeated regularly and at various times to ensure all staff attend. A training register is monitored, and staff are followed up when they haven't attended. Currently 96% of staff are compliant with the mandatory training programme attendance. There are twenty clinical assistants that work in the two dementia units, nineteen have completed the required dementia standards, and one is in process of completing. There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the district health board and through the St Andrews in-service programme. St Andrews ensures RNs are supported to maintain their professional competency. The organisation has an approved professional development and recognition programme in place for all RNs and ENs. This is undertaken in conjunction with Auckland DHB. Registered nurses are supported to attend leadership training. There are 34 RNs working at St Andrews and all 34 are interRAI trained. Attendance at training is paid for by the organisation including external training.

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 staffing rationale and skills mix policy, which provides the documented rationale for determining staffing levels and skill mixes for safe service delivery St Andrews policy is to consistently exceed the recommended requirements set down in the ARRC contract in its rostering for nurses and clinical assistants in all levels of care. Where residents' needs for safe care require a higher level of nursing, duty managers, nurse managers and PM supervisors are authorised to move staff between Houses (as required), and always ensuring that safe staffing levels are maintained across the care facility. Adequate RN cover is provided 24 hours a day, seven days a week. The nursing structure is designed to ensure that there is an access to expert knowledge and advice at all times, either through on duty nurse managers and PM supervisors, or on-call duty manager. Interviews with the residents and relatives confirmed staffing overall was satisfactory. Interviews with 10 clinical assistants and 13 registered nurses confirmed that staffing levels were good across all areas. There are two full-time clinical managers that share cover across the seven homes. They are supported by five nurse managers across the seven houses. House 1 (8 rest home and 21 hospital) AM shift – nurse manager (RN) Monday-Friday. One RN and one EN, six clinical assistants (mix long and short shifts) PM shift – one RN, four clinical assistants (mix long and short shifts) Night shift - two clinical assistants. House 2 - includes 30 hospital beds with full-occupancy AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts) PM shift – one RN, four clinical assistants (mix long and short shifts) Night shift – One float RN and two clinical assistants. House 3 - 29 hospital residents (including one on respite) and two residents on OICP. AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts) PM shift – one RN, four clinical assistants (mix long and short shifts) Night shift –two clinical assistants.

		House 4 – 27 hospital residents including one resident (respite) in Dove wing. AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts). One RN 7.00 am – 7.00 pm in Dove wing, one RN 7.00 pm – 7.00 am PM shift – one RN, four clinical assistants (mix long and short shifts) Night shift – two clinical assistants House 5 – 25 residents across a 30-bed secure dementia unit. AM shift – nurse manager (RN). One RN, five clinical assistants (mix long and short shifts) PM shift – one RN, four clinical assistants (mix long and short shifts) Night shift – two clinical assistants The lodges –20 rest home residents AM shift – EN (with support from nurse manager), three clinical assistants (mix long and short shifts) PM shift – three clinical assistants (mix long and short shifts) Night shift –two clinical assistants Stirling Lodge – 9 residents in a secure dementia unit AM shift – two clinical assistants (one on 12-hour shift) PM shift – two clinical assistants (one on 12-hour shift) Night shift – one clinical assistant There is a team of nine trained diversional therapists and one activity assistant. There is an internal float of 10 staff. Medex agency is used for bureau staff. Bureau staff use is monitored as part of business quality indicators and is identified as low.
Standard 1.2.9:	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial

Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant clinical assistant or nurse, including designation. The service has upgraded their IT infra-structure in order that they can move to a fully integrated IT system, encompassing clinical, HR, accounts, payroll and asset management components.
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	There are policies and procedures to safely guide service provision and entry to services. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the health and disability code of rights, how to access advocacy and the complaints process. There is specific information for those residents being admitted to the dementia units. Entry to the service is coordinated by the admissions manager in consultation with the relevant clinical manager. Information gathered prior to and on admission is retained in the residents' records. Relatives interviewed stated they were well informed upon admission. Fourteen admission agreements viewed were signed. The admission agreement reviewed aligns with the service's contracts. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. St Andrews village uses the yellow envelope system for transfer to and from the ADHB. The nurse managers interviewed verified the process for transfer to ADHB. The family are informed of any transfers. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made and this is documented. Transfer documentation using the yellow envelope system was sighted in one resident (hospital level care) record transferred from the DHB to the facility. The GP was involved and medical notes evidence discussion with the hospital registrar. Documentation evidences families were notified in a timely manner. Progress notes documented the safe transfers by ambulance.
Standard 1.3.12: Medicine Management	FA	There are clearly documented policies and procedures documented and implemented for medication management. Access to medication information is readily available either electronically or in hard copy. All

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		medications are stored safely in the medication room of each of the five houses and lodges. The supplying pharmacy deliver the medication robotic packs monthly or earlier if required. All medications are checked on delivery by the RN against the medication chart (documented within Med-Map) and any pharmacy errors are recorded and fed back to the supplying pharmacy. The robotic rolls are delivered monthly or earlier if required and are checked to ensure they are correct with the medication sheet. Evidence is seen of a separate signing sheet for RNs to sign when checking rolls on arrival. Each resident's allergies are established during admission assessment and documented in the electronic medication administration chart. Any allergies or sensitivities are clearly noted on the medication administration chart. If no allergies are known, then this is documented to identify that it has been checked. Self-medicating residents have a competency assessment completed by the GP. Monitoring the administration of medications for self-medicating residents occur. Two persons sign the administration form for controlled drugs. Self-administration of medication must be noted on the resident's care plan. There is a current medication competent person signing list and all staff sign the administration signing register. Oxygen cylinders, oxygen concentrators and emergency equipment are checked weekly. Clinical assistants and RNs complete annual medication competencies including separate competencies for insulin and warfarin and attend annual education provided by the supplying pharmacy. RNs attend syringe driver education. Twenty-eight medication charts sampled across all seven houses had recent photograph identification and allergies documented. All medication charts have been reviewed three monthly. The medication fridges are checked weekly and corrective actions (sighted) are taken when temperatures are outside of the acceptable range. All medications in trolleys are within the expiry date and eye drops dated on opening. The RNs in all areas were observed during the lunchtime medicines round and correct procedures are followed. There was one resident self-medicating on the day of the audit and all requirements are met. The RNs interviewed were knowledgeable about medication management. The standing orders are up-to-date and comply with legislative requirements. The use of 'as required' (PRN) medications are monitored and electronically signed with times and purpose of administration. The service has a specific fridge for the storage of vaccines. They have a current cold chain accreditation and fridge monitoring records were up-to-date.
Standard 1.3.13: Nutrition, Safe Food,	FA	All baking and meals are cooked on-site at St Andrews by both fully qualified and apprentice chefs out of the newly re-built kitchen. The kitchen is spacious and includes areas for food preparation, cooking, baking, serving

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		and cleaning areas. There are four chillers and walk-in freezers/fridges. The kitchen includes all new equipment from Southern Hospitality. There is a team of kitchen staff including a catering manager, two qualified chefs, two apprentice chefs and eight kitchen assistants. All kitchen assistants have either completed or are going through a national training programme. Kitchen staff are supported to complete the level two catering assistant course. All kitchen staff have completed food handling through orientation and via external national programmes. The summer and winter menus are reviewed annually by an external consultant dietitian. There is access to a community dietitian. Food is plated within the kitchen on individually named trays and then transported to each house in covered trolleys. Cooked/served food temperatures are completed prior to transport and completed before serving as part of the internal audit programme (records sighted). Kitchen fridge/freezer temperatures and food temperatures are monitored at least daily. Corrective actions for temperatures outside of range are documented and re-tested. Food stored in the fridge and chillers is covered and dated. There are designated chillers for dairy, meat and vegetable/grocery items. Dry goods are stored in dated sealed containers in the pantry and kept off the ground. Chemicals are stored safely. Cleaning schedules were sighted and maintained. The service has a food plan registered with MPI and is awaiting a site audit before their grade can be confirmed. St Andrews has an organisational process whereby all residents have a nutritional profile completed on admission, a copy of which is provided to the Catering Manager who is also notified (daily where necessary) of any dietary changes, weight loss or other dietary requirements. Menu choices are completed (documented) daily by staff which include any likes/dislikes or specific choices by the residents for meal options that day. There are three choices for the lunch meal and two choices at night. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. The residents named meal tray includes key alerts regarding allergies or food dislikes/preference on the card for staff reference. The catering manager advised that a tray of sandwiches, fruit and biscuits are provided to the dementia units daily for extra snacks across 24/7. There is a small open-plan kitchen at Stirling Lodge and this is used by staff and residents as per daily activities. Special equipment such as 'lipped plates' and built-up spoons are available as required.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to	FA	St Andrews Village has an accepting/declining entry to service policy. The referral agency and potential resident and/or family member is informed of the reason for declining entry. The admissions manager reports this rarely occurs as they have close contact with the ADHB referrers and community nurses. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents.

the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Admission documentation includes information obtained on interview with resident/relative or advocate, from medical discharge summaries, and from needs assessors. The RNs complete an initial assessment on admission, including risk assessment tools as appropriate. The facility has embedded the interRAI assessment protocols within its current documentation. St Andrews initial assessment, short and long-term care plan templates were comprehensively completed in all 14 resident files reviewed. InterRAI assessments including assessment summary, MDS comments and client summary reports were evident in printed format in all files. An interRAI reassessment has been completed where health changes for residents have occurred. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. In all fourteen resident files reviewed (three rest home, seven hospital, four dementia), assessments were conducted within the required timeframes and assessed needs were reflected in the care plans. The long-term care plans reflect the outcome of the assessments. All four dementia files reviewed identified that risk assessments have been completed on admission and reviewed at least six-monthly as part of the evaluation and multi-disciplinary review process. Challenging behaviour assessments were completed where needed. Residents on orthopaedic interim care programme contracts (OICP) are assessed on admission and as required using the OICP documentation and OICP information folder. Regular assessments (such as pain assessments) were completed for the resident in Dove wing.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Three rest home and seven hospital files reviewed included an initial assessment and (initial) short-term care plan. Long-term care plans were in place for eight residents. One resident was a respite resident and did not require a LTCP but had a specific short-term care plan in place. The resident admitted on an orthopaedic interim care programme (OICP) had a documented care plan reviewed by the RN each shift. Short-term care plans are available for use to document any changes in health needs. Short-term care plans were evidenced for pressure injuries, skin tears, return from hospital admissions, weight loss, and urinary tract infections. Four dementia files reviewed included an initial assessment and (initial) short-term care plan. All four care plans reviewed evidenced clear interventions to support current needs and demonstrated service integration and input from allied health. Short-term care plans reviewed across all areas were evaluated at regular intervals and either resolved or added

		to the long-term care plan if an ongoing problem. Medical GP notes and allied health professional progress notes were evident in the ten residents integrated files sampled. Relatives interviewed were positive and complimentary about the staff, clinical and medical care provided and confirmed they are kept informed of any significant events and changes in health status. Family contact forms sighted in the resident individual record evidenced family are informed of any health changes, incidents/accidents, infections, specialist visits, care plan review, weight loss. Family are invited to attend care review meetings. The multidisciplinary approach is observed with input encouraged and this is evident in the assessments and in the integrated progress records sighted.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Family members and residents interviewed reported the residents' needs were being appropriately met. Care plans identify the resident's problems/needs, objectives and interventions to assist the resident in achieving their goals. Clinical assistants interviewed across all areas reported that they are informed of any changes in health status at handover between shifts and handover records are maintained. In all files reviewed there is evidence of the interventions relating to the residents' assessed needs and desired outcomes. When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file. Documentation evidenced RN oversight of resident care, additional assessments and/or monitoring records, ie, pain assessment and repositioning charts were sighted Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access to a wound nurse specialist and district nurses for advice for wound management. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Wound documentation in all seven units were reviewed. Each unit had an individualised wound register with a wound assessment and management plan for each separate wound. A sample of plans reviewed (including dressing type and evaluations on change of dressings). Photographs are taken of chronic wounds and pressure injuries. The clinical manager, and registered nurses interviewed described the referral process should they require assistance from a wound specialist or continence nurse. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The full-time activities team leader oversees a group of ten activities staff. All team members are fully qualified diversional therapists (DTs) and maintain their skills by attending an annual professional development day. Seven activities staff work full-time Monday to Friday, eight hours a day. Three part-time staff work between two and four and a half hours a day assisting with afternoon and weekend activities. Weekend cover is provided in the dementia unit for three and a half hours every Saturday and alternate Sundays. One full-time DT works in each of the five main houses with an additional part-time support in the two dementia units. The team rotates around each of the units on a three-monthly roster. The team is supported by a group of 25 volunteers (including high school students) who undergo police vetting and a comprehensive orientation. St Andrews is affiliated with an accredited DT training programme and hosts students over a five-week course throughout the year. There are six separate activity areas and one large central area for combined events. Each separate unit has individual programmes and the residents are encouraged to attend the main area for special events. A new initiative, “the Journey of my Life form”, is completed by family as part of the resident’s admission. An activity assessment is completed on admission with an individualised activity plan as part of the long-term care plan developed within the first three weeks. Files sampled evidenced six-monthly reviews in conjunction with care plans. An attendance form is maintained that indicates attendance at activities. Residents and families interviewed commented positively on the variety of activities offered. The activity team focusses on an all-inclusive approach to activities. The weekly programme is in large print and delivered to the bedrooms and displayed on noticeboards. A variety of group activities are offered. Weekly programmes are tailored to residents needs and abilities. Activities provided within the dementia unit are appropriate for the assessed abilities and interest of the residents, which include van outings and visits to the facility by various community groups, ie, “Baby Cuddles” and a local kindergarten group visits. The visits of resident/family pets to the units are also encouraged and were sighted on the day of audit. Activities are delivered by both activities staff and supported by care staff at other times. Within the main dementia unit there are also several quiet ‘interest nooks’ including a baby’s nursery, sports corner and sensory equipment. The newer Stirling Lodge dementia unit has an expansive outdoor garden and rubber paved pathway around the unit and there are plans to introduce a gardening group for those interested. All staff are trained around managing behaviours that challenge and de-escalation. The DT facilitates the resident monthly meetings where the activity programme is discussed, and feedback sought as well as suggestions and ideas for the programme. On admission of a new resident, the DT involves the resident and family to complete a resident profile. The service has exceeded the required standard around activities staff education, pastoral services, and increased resident satisfaction.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The GP completes one to three monthly resident reviews (including a medication review) and more frequently where required. Written evaluations within long-term care plans reviewed across the seven units described the resident's progress against the residents identified goals. InterRAI assessments had been completed in conjunction with the six-monthly reviews. Overall short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review (MDR) involves gaining written input from the RN, GP, physiotherapist, activities staff and resident/family. If unable to attend, family are notified of the outcome of the review and a copy of the care plan is sent to them. Relatives interviewed confirmed involvement in the care review meetings. The respite file evidenced weekly reviews. The OICP care plan reviewed included a weekly assessment and review. Evaluations occur weekly for the OICP resident.
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	Referral processes are documented and in place to guide staff and examples will be followed during the site audit to ensure residents are supported and referrals are appropriately facilitated to meet the needs of residents receiving services in this organisation. Residents have the option to use their own GP or one of the four resident doctors. Residents interviewed report they are given the choice of retaining their own GP but usually change as it is easier to see the GP when he visits. Discussions with the clinical manager, three nurse managers and seven registered nurses identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian and other allied health professionals. The GP initiates referrals to specialists and consultants. Transport is provided for residents to attend external appointments in the community as required. If a resident wishes to change facilities to another health and disability service, the NASC service is contacted and the service provider assists as much as possible with arranging the transfer once approved by the NASC service coordinator concerned. Examples of referrals sighted were to; district nurses, dietitian, geriatrician, dental, older persons mental health service, podiatry, physiotherapy, wound care specialist, eye specialist. There is evidence of GP discussion with families regarding referrals for treatment and options of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	There are documented processes for waste management. The policies document procedures for the safe and appropriate storage, management, use and control and disposal of waste and hazardous substances. There is a large laundry in the main building, with an additional small home-like laundry for personal items to be managed in Stirling Lodge. Chemicals are stored securely in a dedicated locked hazardous chemical storage shed which is accessed by the chemical contractors and maintenance staff as required. PPE & material safety datasheets were sighted as available in this shed. Chemicals used in other parts of the facility are securely stored in lockable cleaners' trolleys or locked cupboards within the houses

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		Waste management audits are part of the internal audit programme. All staff are required to complete training regarding the management of waste during induction. Chemical safety training is a component of the compulsory two-yearly training and orientation training. The maintenance team have also completed other relevant training sessions. Gloves, aprons and goggles are available in the sluice and cleaners' cupboards within the adjoining rest home, which can be accessed by staff as needed. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Training on the use of PPE is included in the general induction programme for all staff There was ready access to additional PPE for staff, for use on shift and dedicated infection control outbreak kits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The facility including all seven houses, is fit for purpose and spacious with a current building warrant of fitness due for renewal June 2018. The facility is made up of seven houses. All resident rooms are single, spacious and personalised. Communal areas within each house are easily accessed with appropriate seating, shading and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. General living areas and resident rooms are appropriately heated and ventilated via gas heaters and underfloor heating. Ventilation is through opening doors and windows. Hot water is also heated by a gas hot water system and temperatures are monitored in each house monthly. Hot water temperatures checks are conducted and recorded monthly by one of the maintenance personnel. Review of the records revealed temperatures in various areas were above required standards. There are call bells and emergency bells in all resident rooms and common areas. The system software is able to be monitored. Staff in Stirling Lodge also wear call bell pendants to call for assistance in an emergency. There is a maintenance team that manages reactive and preventative maintenance at St Andrews. This includes the facilities manager responsible for maintenance, grounds and painting team, the preventative maintenance supervisor responsible for coordinating contract/equipment supply maintenance and the maintenance team leader (a qualified practicing electrician who oversees the newly employed plumber) and four other maintenance staff. There is someone on call 24-hours. All medical equipment is calibrated, and testing and tagging is up-to-date. A reactive and preventative maintenance programme is well established and implemented. The corridors throughout the facility are wide with handrails and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required.

		The external areas are all landscaped. There is outdoor furniture and shaded areas. There is wheelchair access to all areas. There are environmental audits and building compliance audits completed as part of the internal audit programme.
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	All resident rooms are single rooms with ensuites. The rest home and the Stirling Lodge dementia unit have toilet and basin ensuites with shared showering facilities. The remaining rooms throughout the facility have full shower and toilet ensuites. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and hygienic state. Regular audits of the environment are completed as per the quality programme. Residents interviewed state their privacy and dignity are maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are provided within the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs and are sufficient to meet the needs of the residents.
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 room to safely manoeuvre mobility aids in the resident bedrooms. Mobility aids can be managed in ensuites and communal toilets/bathrooms in all areas. Residents and family/whānau are encouraged to personalise their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe,	FA	Communal areas within each house include open plan lounges and dining areas. There are courtyards with seating and shade. The communal areas are easily accessible for residents. Seating and space is arranged to allow both individual and group activities to occur. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents and relatives interviewed report they can move around the facility and there are

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		different lounges and areas to enjoy.
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 laundry manual and cleaning procedures available. The laundry is large and is suitable to manage all laundry on-site with clearly identified dirty and clean laundry flow and storage areas. There is an internal audit around laundry services completed twice each year as per internal audit schedule. Chemicals are connected to washing machines by the chemical contractors for safe, automatic use. Staff attend infection control education and there is appropriate protective clothing such as aprons and gloves available. There are dedicated laundry and cleaning staff. Manufacturer's data safety sheets are available. The cleaners' cupboards are designated areas and lockable for storage of chemicals, and are stored securely. Residents and relatives interviewed confirmed satisfaction with the laundry and cleaning.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The organisation has a documented emergency and disaster plan in place as per the Health and Safety programme. Six monthly trial fire evacuations are conducted. Fire and emergency training is included in staff orientation and regular ongoing sessions are undertaken throughout the year. Civil defence and emergency supplies are checked every quarter. The service ensures there is emergency food and water for a minimum of three days. The emergency water tanks (two 25,000 litre tanks) have pumps which operate if the water pressure drops. There has been significant investment by the organisation in the upgrade of the electrical system, which if required, can support provision of power to the entire site by up to four generators. A new 550kva generator is able to provide 100% power to the main care facility, including kitchen, laundry and administration allowing the service to continue operating independently. A new generator has also been installed to service the lodges and new dementia unit, providing full functioning to these houses in an emergency (link 1.4.7.4). There is an Emergency Response room off reception in the main building, which specifically includes procedures, analogue phones, torches, first aid kits etc. Policies and procedures have been updated. The CEO has also attended external training in leading and managing a major emergency and an emergency scenario has been trialled. The emergency management policies include (but are not limited to): dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. An emergency response room audit is also

		carried out six monthly. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. There are staff employed across 24/7 with a current first aid certificate. Staff are required to ensure doors and windows are securely closed at night. There is an approved security company who undertakes three nightly random checks of all buildings and the grounds. This service uses satellite monitoring to show which areas are checked. There is CCTV around the grounds which can be monitored as required. There are documented security procedures. There are call bells and emergency bells in all resident rooms and communal areas. The system software can be monitored. Staff in Stirling Lodge wear call bell pendants to get assistance in an emergency.
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	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Residents and relatives interviewed were happy with the temperatures and the environment.
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 are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator (IPC) is a registered nurse and she is responsible for infection control across the facility. The IPC committee in conjunction with the CQR committee, is responsible for the development of the infection control programme and its review. The infection control programme is well established at St Andrews. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, and GPs as needed. There have been two small gastric outbreaks since the previous audit. In June and again in September, the duration of each outbreak was short (respectively two and six days). These were confined to two houses. A case log was maintained, and Public Health notified. An outbreak summary report was completed post outbreaks. Interviews and documentation reviewed identified the outbreaks were well managed.

		The service has initiated the measuring of months between outbreaks as a quality indicator, and were pleased to be up to 24 months in June 2017, before the two minor outbreaks of gastroenteritis. They have done significant improvement work developing Outbreak Response Kits, based on Bug Control guidelines and Australian best practice and now have very good processes regarding decision making and response. Although their goal is to avoid outbreaks altogether, evaluation shows they have responded quickly as a team and prevented the spread of the outbreaks.
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	There are adequate resources to implement the infection control programme at St Andrews. The infection control (IPC) coordinator is new to the role and supported by the clinical manager (CM) who has maintained best practice by attending infection control updates through Bug control. The infection control committee is representative of the facility. The service subscribes to Bug Control and use their material for reference. The IPC coordinator, CM and other clinical staff attend regular training provided by Bug Control and ADHB. They consult with Public Health regarding outbreak questions, and with their medical team and ADHB specialist nurses for questions regarding the care of individuals. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
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	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control committee, training and education of staff and scope of the programme.

practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The IPC coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around (but not limited to) hand hygiene and standard precautions. Infection control training is part of the mandatory training programme and regularly held to ensure all staff attend at least annually (refer stats 1.2.7.5). The IPC coordinator has received education both in-house training and by an external provider to enhance her skills and knowledge. The infection control coordinator has access to resources, guidelines best practice and simple solutions benchmarking. A number of toolbox talks have also been provided at handovers.
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	The IPC programme and management policy describes and outlines the purpose and methodology for the surveillance of infections. Identifying infections (for surveillance purposes) document, provides a link to surveillance data gathered. The IPC coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service participates in a benchmarking programme with 27 other ARC facilities and receive quarterly reports (Simple Solutions). These are analysed, trends identified, and corrective actions established where needed Effective monitoring is the responsibility of the IPC coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. A monthly report is provided to all houses in relation to IPC feedback. This includes benchmarking outcomes, data analysis and recommendations. Internal audit results are provided for each house/area with recommendations where needed. Graphs are on noticeboards in each house.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint	FA	The restraint minimisation and safe practice policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through meetings, and CQR meetings. Interviews with the staff confirm their understanding of restraints and enablers.

is actively minimised.		Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were four residents assessed as needing restraint for safety. There were seven residents with enablers in the form of bedrails. All enabler use was voluntary and consented. One resident file of enabler use was reviewed. The enabler consent and assessment form were completed and signed. The care plan identified the enabler use and risks were documented. These had been evaluated at least three monthly.
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	There is a 'responsibilities and accountabilities' described in the restraint policy for all key staff. The restraint coordinator is a nurse manager and has a signed job description, and understands the role and his accountabilities. All staff complete mandatory restraint training. There is a restraint approval flowchart that describes the process for approval. The restraint coordinator checks and reviews all restraint assessments.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Files were reviewed of two residents identified as requiring restraint on the restraint register. Both files reviewed included a restraint assessment tool. The assessment identified alternatives tried and those listed in 2.2.2.1. The care plans were up-to-date and provided the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified and consents documented. InterRAI assessments identified potential risks and need for restraint.
Standard 2.2.3: Safe Restraint Use	FA	The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes

Services use restraint safely		ensuring the environment is appropriate and safe. The two resident files reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plans reviewed identified interventions to manage risks and monitoring. Restraint use is reviewed on implementation at the first month mark, then through three-monthly evaluations, monthly restraint meetings and six-monthly care plan reviews and multidisciplinary (MDR) meetings and includes family/whānau input. A restraint register is in place, which has been completed for the four residents requiring restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred monthly as part of the ongoing reassessment for the resident on the restraint register, and through three-monthly evaluations, monthly restraint meetings and six-monthly care plan reviews and multidisciplinary (MDR) meetings. The family is included as part of the MDR review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Having received a partial attainment for aspects of their restraint minimisation programme at their last surveillance audit in November 2015, the service completely reviewed and overhauled their documentation and procedures regarding restraint minimisation and safe practice. The partial attainment related primarily to the use of personal restraint, however, the entire programme underwent review. They also increased the frequency of the restraint committee meeting from quarterly to monthly, in order to closely monitor progress. There has been a decline in restraint use overall (from over 20 restraints in 2015, down to 4 restraints in November 2017). There have been no instances of the use of personal restraint since June 2016 to YTD.

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 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The facility including all seven houses, is fit for purpose and spacious with a current building warrant of fitness due for renewal June 2018. All resident rooms are single, spacious and personalised. A reactive and preventative maintenance programme is well established and implemented. The corridors throughout the facility are wide with handrails, and promote safe mobility with the use of mobility aids and transferring equipment. All water temperatures are recorded in rotating locations throughout the facility on a monthly basis. Where temperatures were out of range, tempering valves on the gas heating system were easily able to be adjusted	Hot water temperature recordings reviewed showed several temperatures recorded above 45 degrees Celsius for the past 6 months, with no documented evidence of corrective action having been taken	Ensure all resident area water temperatures are maintained at no higher than 45 degrees Celsius. 90 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 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	St Andrew’s takes a leading role within the residential aged care sector on national issues such as workforce planning and immigration. The service has specific DHB-funded beds in House 3 (Bruce wing). There are three Orthopaedic Interim Care Programme beds [OICP] with two residents currently. The Interim Care Programme has been introduced and bedded down, with positive feedback from the programme organisers. Staff are trained in rehabilitation and identifying resident-centred goals to assist a resident to go home. Physiotherapy services are provided on-site, five days per week with the support of four physiotherapy assistants. The service has initiated the implementation of ISBAR as the expected tool for communicating	St Andrews has robust quality and risk management systems’ which are implemented and supported by a number of meetings held on a regular basis. St Andrews has been proactive around implementing quality initiatives, these are established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness. There have been a number implemented including (but not limited to); 1. Introduction of ISBAR. The project was implemented following review of files following complaints and serious incidents in 2014-2016 which revealed several instances of inadequate communication or escalation of clinical concerns. Improvement work has included: Communication policy developed, Coaching of RNs to communicate using ISBAR, coaching of senior nursing staff and doctors to receive communications in ISBAR style, and ISBAR pockets cards, distributed and

		clinical concerns. This is considered best practice in escalating concerns. The project goal around the implementation if ISBAR is to minimise incidents and complaints relating to communication. The service has a positive relationship with Dove House, the Eastern Bays Hospice who contract three beds at St Andrews. This has led to staff benefiting from their end of life care expertise and training. The service has worked closely also with the ADHB Last Days of Life coordinator to achieve increased rates of residents being on LDL at the time of their death. A quality initiative has been established around this. St Andrew's provides a Pastoral Care team who are available to meet spiritual needs of all residents and their families, regardless of their religion or faith, or residents can be referred to other spiritual care providers if required or requested. The pastoral care team also implements a music workshop every Wednesday. There are currently about 25 members in the choir including residents from the rest home, hospital and dementia unit. This initiative has received a lot of positive feedback from residents/relatives and staff. The service has made the following improvements since previous audit (but not limited to); (i) Complete IT infrastructure replacement has been done in anticipation of the new integrated software; (ii) Brand new commercial kitchen installed; (iii) New purpose-built utilities building; (iv) The commercial laundry has been refurbished with four brand new gas dryers. (v) The entire main care facility and the Lodges now have	promoted June 2016 and ISBAR posters distributed, featuring St Andrew's clinical staff. Feedback from GPs, relatives and staff were positive during the audit around communication. A formal evaluation is planned for January 2018 to see if it has made a difference around complaints etc. 2. Last Days of life (LDL) care plans are promoted as being a best practice pathway for people receiving and of life cares. Therefore, St Andrews considered improving their rates. The first part of the improvement process was to get engagement from all parties, and the matter was raised repeatedly in relevant forums. Advice of the ADHB Last Days of Life Coordinator was sought. This included conducting training sessions for RNs and completing audits. Findings from audits informed the subsequent training sessions. The service monitors as a quality indicator, the rate of deaths for residents who were on the Last Days of Life plans (LDL) at the time of death, compared with the number of deaths. They have been very pleased to see the percentage of residents on LDL at the time of their death increase from 18% in 2015 to 47% YTD 2017. Clinical managers monitor reasons for residents not being on LDL, and discuss with RNs as required.

		automatic emergency generators which supply full power to all areas in the event of a power cut. (vi) They have revamped their emergency procedures and designated an emergency response room, fully kitted out for the purpose of managing a major emergency/disaster; (vii) They have committed to support the training of one of their nurse managers to become a nurse practitioner (due to complete training and final exams in December 2017).	
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	There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six monthly or annually as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited. Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality improvement projects and 'shared learning' are an agenda item in meetings. Monthly reports document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality	St Andrews is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. Example: The service has developed a project around their PIPM programme. This has involved a thorough review of pressure injury management and prevention including review of policy/process, equipment. There is a PI resource nurse appointed and relevant job description. The service commenced gathering of clinical indicators for new PIs developed at St Andrews and those with stage 2 pressure injuries. They identified that early reporting is encouraged, and pressure injury training and skin integrity training provided regularly so all clinical staff are knowledgeable. Each house is presented with a monthly clinical indicator report and analysis. Each new and current PI is individually discussed in the CQR meeting, where strategies and current management is discussed. On evaluation of the effectiveness of these measures, they have identified that early reporting may be contributing to numerous stage one PIs. The results of stage two had minimised through 2017 with a peak in August as a result of a number of residents on 'last days of life' (LDL).

		improvements identified through meeting minutes and as a result of analysis of quality data collected. St Andrews is proactive in developing and implementing quality initiatives.	
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	CI	The service has a proactive health & safety committee and the organisation provides support to encourage staff and contractor involvement at all levels. There are H&S representatives across all houses and other areas of the village including (but not limited to) allied health & quality, household and facilities and executive team. The H&S committee meets monthly and reviews (but not limited to) policy/procedures, any specific H&S issues and staff incidents/accidents. A monthly report is provided that breaks down all accidents/incidents and near misses including any new hazards. The report is presented to the H&S meeting and presented to all houses. There is an electronic hazard register that is a living document. Specific forms are used, and information is transferred onto the hazard register risk report until the issue is eliminated. Regular reviews are undertaken, and the process is fully understood by all staff interviewed. Risks shown cover all aspects of service delivery including financial and business risk. Meeting minutes and other detailed documentation sighted shows how risk management is dealt with and that it is embedded into everyday practice. Staff and management are kept fully informed of any new risks and residents are informed as appropriate.	The achievement of the rating that the service provides an environment that encourages a proactive approach to Health & Safety is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision and staff/contractor safety. Example; staff incidents and accidents are monitored including events related to manual handling and challenging behaviour. Causes are determined, and corrective actions are implemented and shared with staff. Training is regularly provided around manual handling, managing behaviours that challenge, and incidental toolbox talks as a result of learning from events. On evaluation, graphs and analysis identifies consistent reduction in challenging behaviour since February 2017 and manual handling incidents since March 2017.

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	St Andrews is committed to staff support and have introduced staff satisfaction surveys, access to EAP services and significant opportunities for training in areas of staff well-being (for example financial literacy, accessing EAP). They have committed to support the training of one of their nurse managers to become a nurse practitioner (due to complete training and final exams in December 2017). There is a clinical training coordinator (CTC) responsible for ensuring the accessibility of internal and external training for staff. The CTC monitors attendance records to ensure all staff attend mandatory training. There are three dedicated palliative care beds which are contracted by Eastern Bays Hospice. The clinical assistants and registered nurses who work in this area have undertaken specific education provided by the hospice and are approved by them to work in the area. Specialised oversight is undertaken by hospice staff with day-to-day management being overseen by employed RNs.	The achievement of the rating that the service encourages ongoing competence and education is beyond the expected full attainment. A quality goal has been implemented 2016 and 2017 around 'being up to the job'. Education and competence is supported by the board through business goals and financial support. There is a specific clinical training coordinator position that monitors and oversees education. There have been a number of achievements made around training and competency including (but not limited to); (i) 95% of clinical assistants have a national qualification (92 have achieved level 4); (ii) all 34 RNs are interRAI trained; (iii) 96% of staff are compliant with the 21 mandatory training sessions, which are scheduled either annually or two yearly; (iv) all RNs have current syringe driver competencies; (v) staff are supported to complete palliative (end of life care) training and other specific training to support the current needs of residents, ie, rocket drainage training and (vi) there are seven trained vaccinators at St Andrews with more being trained next year. The achievement of a 3-year cold chain accreditation and having trained vaccinators has increased the number of vaccinated residents to 95% in 2017. Staff turn-over remains low, interviews with staff identify a number of long-standing staff and positive feedback around training opportunities available at St Andrews. Staff surveys, training session evaluations, resident and relative surveys completed annually support evaluation of the effectiveness of the training programme.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills,	CI	St Andrews operates an activities programme that is tailored to meet the residents needs and abilities. The programme is developed for each unit taking into consideration the individual residents life journeys and interests.	St Andrews activities team identified that there was an opportunity to improve satisfaction with the activities programme. To achieve this, interventions were planned, implemented and assessed. Pastoral care was enhanced by a full-time pastoral care worker who as part

resources, and interests) that are meaningful to the consumer.		Residents with particular skills or interests such as knitting, card groups or music are offered the opportunity to join others. The activities team is able to resource all required equipment and supplies.	of his role facilitates a choir workshop. St Andrews has supported all activities staff to upskill and complete the diversional therapy qualification. This education has contributed to continuing improvement of the activities programme. An activities statistic form demonstrates that the changes implemented in the activity programme over the past 18 months have increased resident attendance and satisfaction. The annual survey confirms resident satisfaction increased from 75% in November 2015 to 87% in November 2016.
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	CI	There has been significant investment by the organisation in the provision of alternative energy and utility sources. Up to four generators, if required can support provision of full power to the entire site.	A fully equipped room is kept for the designated purpose of overseeing a major emergency. Policies and procedures have been significantly updated to reflect the improved capability. Scenario has been trialled. The CEO has attended external training in leading and managing a major emergency. A new 550kva generator can provide 100% power to the main care facility, including kitchen, laundry and administration allowing the service to continue operating independently, delivering 400kW of power in total. A new generator has also been installed to service the lodges and new dementia unit, providing full functioning to these houses in an emergency. At maximum peak loading, the care facility currently uses only120kW. An additional external fuel tank was installed (sighted) which is an above ground model, with double-skinned construction and a four-hour fire resistance rating. This tank has been Worksafe approved and complies with all secondary containment regulations. Spill containment is also fitted around the filler. Weekly monitoring of the generators readiness is also completed by the Maintenance Team leader (sighted). The service also has a 600L external diesel storage tank on-site (by the Utilities). This fuel will be used for the two supplementary generators, one to be in The Lodges, and

			one in the Community Centre. Current total capacity with current diesel stores is approximately 12-14 hours of electricity supply. In addition, a new 47kva generator has been installed to provide 100% power to the Lodges, including Skye Lodge and Stirling Lodge. It will deliver 37kw of power in total, and will power all appliances to full capacity. This generator uses approximately 5.5l of diesel per hour at 100%, giving a run time of 18 hours before refuelling. This can be increased by limiting non-essential power use. The service also has two 25,000 litre water tanks with automatic pumps that will operate if the water pressure drops. These are also powered by the emergency generators installed should this be required.
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of	CI	The service is proactive in minimising restraint. The restraint committee meets monthly and all restraint and at-risk residents are monitored closely to determine alternatives to restraint. Evaluation of restraint use has also occurred monthly as part of the ongoing reassessment for the resident on the restraint register, and through three-monthly evaluations, monthly restraint meetings and six-monthly care plan reviews and multidisciplinary (MDR) meetings. The family is included as part of the MDR review.	Having received a partial attainment for aspects of their restraint minimisation programme at their last surveillance audit in November 2015, the service completely reviewed and overhauled their documentation and procedures regarding restraint minimisation and safe practice. The partial attainment related primarily to the use of personal restraint, however, the entire programme underwent review. They also increased the frequency of the restraint committee meeting from quarterly to monthly, in order to closely monitor progress. There has been a decline in restraint use overall (from over 20 restraints in 2015, down to 4 restraints in November 2017). There have been no instances of the use of personal restraint since June 2016 to YTD. Restraint minimisation and challenging behaviour is a mandatory training requirement for all staff two yearly (96% of staff have met that requirement).

care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.			

End of the report.