

Te Kauwhata Retirement Trust Board - Aparangi Village Residential Care Unit

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Te Kauwhata Retirement Trust Board
Premises audited:	Aparangi Village Residential Care Unit
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 November 2017 End date: 22 November 2017
Proposed changes to current services (if any):	There has been a reconfiguration of services at Aparangi Village Residential Care Unit. This occurred in February 2017 when the Ministry of Health approved the reconfiguration of five rest home beds to dual

services. The reconfiguration maintains the total number of bed as 56 but now comprises of 20 dual purpose beds and 36 rest home level care beds.

Laundry services have now been contracted to an off-site provider. This did not result in any job losses as the laundry staff member has continued employment under a new contract.

Total beds occupied across all premises included in the audit on the first day of the audit: 47

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Te Kauwhata Retirement Trust Board - Aparangi Village Residential Care Unit (Aparangi Care Unit) provides rest home and hospital level care for up to 56 residents. The service is owned by the Te Kauwhata community and is operated by a board of nine trustees. There is a general manager who oversees all services at the facility including the independent living village which is not included in this audit. A clinical nurse manager oversees the care unit services. The executive administrator assists with management of the village services and attends all board meetings to record minutes, also giving assistance to the general manager as required.

Since the previous audit, services have been reconfigured so that the number of dual purpose beds have increased by five, giving the service a total of 20 dual purpose beds. The reconfiguration maintains the total number of beds (56), but now comprises of 20 dual purpose beds and 36 rest home level care beds.

The laundry services have been taken off site resulting in no job losses as the laundry staff were employed under a new contract.

Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, allied health staff, and the nurse practitioner.

This audit has identified six areas requiring improvement relating to staffing numbers on night duty, documentation of long term care plans, checking of call bells, two issues related to management of restraint, and sharing of infection control surveillance data.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

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

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

A complaints register is maintained with complaints resolved promptly and effectively

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Information related to the monitoring of the services is provided to the governing body (the board) monthly to ensure they are kept fully informed. All services are overseen by the general manager (GM) who is a registered nurse. The care facility clinical nurse manager also holds a current practising certificate. There is also an executive administrator who works across both services as required. All members of management are experienced and suitably qualified for the roles they undertake.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Morning and afternoon shift rosters show that adequate numbers of staff and the skill mix safely meet the needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment and medical equipment are tested at least annually. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating. There is a current building upgrade occurring which considers residents' needs and comfort. No negative comments were made in relation to the external areas or management of ongoing building work at the time of audit.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Except for one resident who likes to do their own personal laundry, laundry is undertaken offsite and evaluated for effectiveness visually. Residents are also asked if they are happy with the service.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The organisation has implemented policies and procedures related to restraint management. Seven enablers and eight restraints are in use at the time of audit. The service undertakes assessment and approval processes regularly. Monitoring timeframes are documented according to identified risk factors. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. The service has a restraint register.

Staff undertake annual restraint minimisation and safe practice education.

Infection prevention and control

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	3	1	1	0
Criteria	0	95	0	4	1	1	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 facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility focuses on the continued integration of its residents and that of their community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible.</p> <p>The clinical nurse manager is responsible for complaints management and follow up, with final signoff by the GM. All complaints are reported at board level monthly as confirmed in meeting minutes and reports sighted.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. There are no outstanding complaints at the time of audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in main foyer areas and in each of the resident's bedrooms. Information on advocacy services, how to make a complaint and feedback forms is found</p>

		in the foyer.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Māori health plan developed with input from cultural advisers; however, the majority of the information gathered is non-specific to the resident and not then reflected in the long-term care plans (please see criterion 1.3.5.2). Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whanau were not available at the time of audit, however documentation in residents' files showed evidence of resident and family communication, involvement and respect of the resident's individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, spiritual beliefs. The residents satisfaction survey confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The nurse practitioner (NP) interviewed stated that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Staff have attended training to support a resident who is significantly sensory impaired, and a long-term care plan developed provides support to the resident and the staff.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual strategic goals and the associated operational plans. Strategic goals are updated monthly. A sample of monthly reports to the board showed adequate information to monitor performance is reported including financial performance, staff, property, planning and funding, emerging risks and issues, health and safety targets and reporting, complaints and corrective actions.</p> <p>Overall services, are managed by a GM who is a registered nurse and holds relevant qualifications.</p>

		<p>She has been in the role for over four years. The clinical nurse manager has worked in the aged care sector for over 10 years with previous management level experience. Her initial employment was as a registered nurse (February 2016) and she moved into the clinical nurse manager's role in May 2017. The executive administrator has previous overseas experience in similar roles and has been in the position since July 2016. The responsibilities and accountabilities for all roles are defined in job descriptions and individual employment agreements.</p> <p>The GM and clinical nurse manager, confirmed their knowledge of the sector, regulatory and reporting requirements. They maintain currency through regular ongoing education and being registered with the Waikato District Health Board (WDHB) professional development and recognition programme to ensure education meets the Nursing Council of NZ requirements. Management education and seminars are attended by members of the management team.</p> <p>The service holds contracts with WDHB for:</p> <ul style="list-style-type: none"> - Residential Respite Services – no residents using this service at the time of audit - Long Term Support Chronic Health Conditions Residential – no residents using this service at the time of audit - Midlands Primary Options Residential Respite Care – no residents using this service at the time of audit - Age Related Residential Care Service for rest home and hospital level care – 43 residents (14 hospital level and 29 rest home level care residents) at the time of audit. <p>Three residents have occupational right agreements (ORAs) and live in the studio units attached to the care facility. Two of these residents are receiving assistance with cares and one is having hotel services only (meals, cleaning and laundry).</p> <p>There are also seven serviced apartments attached to the care facility which residents occupy under ORAs. Care staff are responsible for responding to call bells. (See comments in standard 1.2.8.)</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the</p>	<p>FA</p>	<p>When the GM is absent, the executive administrator, clinical nurse manager and board chair carry out all the required duties under delegated authority. When the clinical nurse manager is absent, a contracted experienced age care RN covers the role. They are able to oversee all clinical processes and take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>

<p>provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wound care and pressure injuries.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality meetings, board meetings, management meetings and health and safety meetings. Quality data results are not a set agenda item for staff meetings (Refer comments in criterion 3.5.7). The results of quality data are printed out for staff and advertised on a common notice board. If a deficit is identified in the quality results, these findings are discussed at shift handovers and written in the communication diary.</p> <p>Staff reported their involvement in quality and risk management activities through regular audit activities and implementation of corrective actions. Quality improvements and quality data results are measured against strategic planning goals set by the board.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed that both residents and families were satisfied with services. Two residents identified that staff did not always knock on their bedroom door prior to entering. This was discussed at staff meetings and additional education was presented related to residents' rights. Residents were then resurveyed with no negative comments being made. Residents and families interviewed did not identify any concerns about privacy during the audit.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an off-site provider and based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM and clinical nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The GM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. This was confirmed in the detailed health and safety plans which have mitigation actions, and the person responsible to ensure actions have been completed. Health and safety goals are discussed monthly at the health and safety committee meetings and at monthly board level reviews.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Family are kept informed as confirmed during interviews. Adverse event data is collated, analysed and reported to the senior management team and at board level monthly.</p> <p>The GM and clinical nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one pressure injury made to the Ministry of Health, using section 31 reporting, since the previous audit. There have been two uncontrollable event notices made. One in October 2015 which was investigated by the coroner and closed in February 2016 with no follow up required. The second event occurred in November 2016 and was closed by the coroner in March 2017 with no follow up required. However, the service put a corrective action in place at facility level following the 2016 report. This has resulted in residents having hourly checks when in their bedrooms using 'Intentional rounding forms'.</p> <p>There have been no police investigations, issues based audits and any other notifications, such as public health, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three-weeks and then annually.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. This was confirmed in the employment levels (four on level four, eight on level three and one on level two). A staff member is the internal assessor for the programme.</p> <p>There are sufficient trained and competent registered nurses (three who have full interRAI access and two with management access only), who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA High</p>	<p>There is a documented process for determining staffing levels and skill mixes. This is shown in the morning and afternoon rosters sighted. The GM and clinical nurse manager stated the facility adjusts staffing levels to meet the changing acuity level of residents. For example, if there is an end stage palliative care resident an additional staff member may be required. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff on morning and afternoon duty reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. The service is able to use interRAI information in relation to supporting staffing decisions.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the facility. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided for morning and afternoon shifts, with staff replaced in any unplanned absence across all shifts. However, owing to a recent reconfiguration of the internal placement of residents' bedrooms and staff being responsible to respond to call bells for residents who are under ORA contracts, the night staff find it difficult to manage.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP/NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Disability and support (DSL) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual</p>

		requirements. Service charges comply with contractual requirements.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed supporting relevant documentation. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines.</p> <p>There are two residents who self-administer medications at the time of audit. One of the two resident's medication sighted was not in a secure location in their bedroom; by the end of the audit this medication was returned to the treatment room as the resident is unable to unlock their draw to</p>

		<p>obtain the medication when required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by one of two cooks and a kitchen team who is overseen by a co-ordinator, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The general manager stated that the approved food safety plan is due to be submitted to the council for consideration. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan on an electronic device. The co-ordinator and cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the needs assessment service (DSL) is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to DSL is made and a new placement found, in consultation with the resident and whanau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. However, the needs identified by the interRAI assessments were not always reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is not always documented in the long-term care plans but is verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>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.</p>	<p>FA</p>	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy, an activities co-ordinator completing a diversional therapist apprenticeship and an activities co-ordinator currently completing diversional therapy training.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life. The facility's focus is to ensure that the residents remain integrated within the community and this includes partaking in normal community activities with individual, group activities and regular events offered and attended. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings</p>

		and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and enjoyable.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the NP, GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to hospice, mental health services for older people, and the dietician. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. The facility has secure storage areas for waste whilst pick up is awaited. Recycling occurs and includes fat, oil and plastic. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff.</p> <p>Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment (PPE) and staff were observed using this. Staff confirmed they have unrestricted use of PPE.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 22 April 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (May 2017) and calibration of bio medical equipment (June 2017) is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>The service has adequate lifting equipment including ceiling hoists in seven of the newly reconfigured bedrooms with plans to increase this number over the next two years. This caters for the increase of hospital level beds to 20.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. All external areas have appropriate seating and shaded areas for resident use. The facility also supplies sun hats and sun screen for residents and staff when required.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and any requests are appropriately actioned. Residents and family confirmed that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all bedrooms having toilet ensembles and one bedroom has full ensuite facilities. There are separate staff and visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There is a bariatric toilet chair should it be required.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Bedrooms are personalised with furnishings, photos and other personal items displayed. All bedroom doors are wide enough to use mobile lifting equipment to go into the room and all bedrooms are of adequate size for the resident group, either rest home or hospital level care. It is appropriate for the increase of five additional bedrooms to be used for dual purpose.</p>

<p>group and setting.</p>		<p>The service has a dedicated palliative care bedroom which has a fold-away bed built into the wall to allow relatives to stay with their relatives.</p> <p>There is room to store mobility aids and wheel chairs. There is a dedicated mobility scooter bay which allows all scooters to be charged when not in use.</p> <p>Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. At the time of audit there is an upgrade occurring to the main dining area. This is being managed to meet all health and safety requirements and alternative dining areas have been set up. The dining and lounge areas are appropriately furnished and enable easy access for residents and staff. Residents can access areas for privacy, if required. Residents are happy with the areas provided.</p> <p>Residents also have access to a library and hall which is used for a large variety of activities, many of which are shared with village residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Since the previous audit, laundry services have been contracted to an off-site provider. However, there is still an area available to allow residents to continue to do their own personal washing if they choose to do so. There is a dedicated staff member who returns residents' personal clothing to their bedrooms. Residents confirmed during interview that this process works well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. One staff member has completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), and another staff member is part way through these papers as confirmed in interview of cleaning staff and training records.</p> <p>Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme with monthly checks being conducted as part of the environmental audits. Visual checks are undertaken of laundry daily when it is unpacked.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	<p>PA Low</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>evacuation plan was approved by the New Zealand Fire Service on the 27 February 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 25 July 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 56 residents. Water storage tanks are located around the complex, and there is a diesel generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. The current call bell system does not allow for the response times to be monitored. The service is committed to upgrading this system and documentation identifies that this is to occur in the near future. Only three randomly chosen call bells are checked each month as part of the environmental audit to ensure they are in good working order. The service is in the process of formalising this process to ensure all call bells are checked on a more regular basis. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the local community security company checks the premises at least twice each night at random times.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto outside garden areas. Heating is provided by centrally heated gas fired radiators with thermostats located in each resident's bedroom and in the communal areas. There are also heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the clinical nurse manager. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical nurse manager and tabled at the quality/risk committee meeting. This committee includes the general manager, clinical nurse manager, IPC coordinator, the health and safety officer, and</p>

		<p>representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. She has undertaken a certificate in infection prevention and control and attended in-service training, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, IPC coordinator and the clinical nurse manager. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there</p>

<p>consumers.</p>		<p>was evidence that additional staff education had been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather, with training last occurring in June 2017.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>PA Moderate</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated but is not analysed in detail to identify any trends, possible causative factors, required actions and does not reflect residents who frequently have infections or interventions required (please refer to criterion 1.3.5.2). Results of the surveillance programme are not always shared with registered staff and results are not shared in meetings with care staff via regular staff meetings. This was evident at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years, and this is reported to the clinical manager, general manager and the board of directors. Data is benchmarked externally within the group. It was highlighted by the auditor at the time of audit that infections are higher than average; however, on investigation this was found to be due to three residents who frequently have infections. This information was not highlighted or analysed at the time of monthly surveillance and actions advised as a consequence.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (clinical nurse manager) provides support and oversight for enabler and restraint management in the facility. She understands her role and responsibilities.</p> <p>On the day of audit, six residents were using restraints (one resident had two restraint devices) and eight residents were using enablers (one resident used two devices), which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the restraint coordinator, registered nurse and GP or nurse practitioner, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator and RN interviewed described the documented process. Families confirmed their involvement. The general practitioner or nurse practitioner are involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, such as the use of sensor mats and low beds.</p> <p>Policy states that when restraints are in use, monitoring timeframes are identified according to the level of risk but never more than two hourly intervals. Records of monitoring were not maintained to meet timeframes shown. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint. It identified five restraints and 10 enablers. However, two of the enablers were not voluntary and should be restraints.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during interRAI reviews, and by the restraint approval group. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The documented evaluation process covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the GM, board and staff. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the RNs, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator confirmed that the use of restraint has been reduced by two over the past 12 months.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA High	<p>Policy identifies the process to determine service provider levels and skill mixes. Rosters show that unplanned staff absences are covered for all shifts. The service has recently been reconfigured and is now more spread-out than in the past, but there remains two staff on night duty. The layout of the facility would not allow staff to hear a resident if they call for help if they cannot use their call bells. (Refer comment in criterion 1.4.7.5). There are 14 hospital level care residents and if both staff are working with a resident, possibly using lifting equipment, other residents have to wait for their call bells to be answered. Floor staff are also expected to respond to call bells from residents holding an occupational right agreement (ORA) living in</p>	<p>The service has recently been reconfigured and is now more spread-out than in the past. The number of staff on night duty does not take into consideration the lay-out of the facility which is required to meet ARRC requirements under section D17.4 (a) (iii). There are two staff on duty overnight. Staff stated their concerns about being able to meet resident needs in a timely manner on night duty. Staff reported they cannot take their allocated breaks</p>	<p>Provide evidence that safe staffing levels are provided across all shifts to meet contractual requirements, specifically night duty staffing levels which must consider the lay-out of the facility and</p>

		<p>seven serviced apartments and three care units. These dwellings are attached to the care facility but are located on separate peripheral wings of the building.</p> <p>Interviews with two night staff identified that residents often had to wait to have their call bells responded to, that staff are unable to take breaks, and if they do get time for a break, it is interrupted to assist with cares. Staff stated that it is especially difficult between the hours of 4am to 6am when residents need assistance to go to the bathroom. A review of incident forms demonstrated that there is a reasonably high level of falls between the hours of 10 pm and 6.30 am. For example, in April 2017, there were 12 falls in total with only three between 10pm and 0630am. However, following the reconfiguration of the building, the July, August September and October falls data identified that the number of falls during these hours is equal to or more than any other time during the 24 hour period. (Falls times are measured from 8am to 12md, 12md to 4.30pm, 4.30pm to 5.30pm, 5.30pm to 10pm, and 10pm to 6.30am).</p> <p>The service adjusted the night staff levels from the day of audit to three staff on for the shift.</p>	<p>without interruption. These concerns are supported by falls data reviewed for 2017 which shows resident fall frequency has increased between the hours of 10pm to 6.30am since the reconfiguration.</p>	<p>allow for the addition staff time taken for the oversight and call bell response for ORA residents.</p> <p>1 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>All residents admitted to the facility had assessment tools completed which included interRAI. It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. Seven residents' files were reviewed, there was evidence of updates and reviews to long term care plans when changes occurred;</p>	<p>InterRAI assessment findings including Maori health care beliefs and residents with chronic infections do not consistently have this information and/or interventions reflected in residents' long-term care</p>	<p>Provide evidence that long term care plans identify all residents' needs as reflected in interRAI</p>

		however long term plans did not always reflect information that was detailed in the six monthly interRAI assessment (eg, personal cares and the level of dependence of the resident and support required). Two of seven residents who identify as Maori, did not have documented in their long-term care plans interventions to support their cultural beliefs and values. Three of seven residents did not have documented in their long-term care plans evidence to show frequency of infections and interventions required.	plans.	findings and outcomes, including cultural requirements and chronic infections. 180 days
Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	PA Low	All resident areas have a call bell to summons assistance when required. If it is identified that a call bell is not working, this is managed promptly via the corrective maintenance process. However, there is no formalised system in place to ensure regular checks of all call bells are undertaken. Three call bells per month are checked during the environmental audit but this is a random check and is not formalised. (Refer comments in standard 1.2.8 related to the facility lay-out which would make it very difficult for staff to hear a resident if they called out for assistance).	There is no formalised system in place to ensure all call bells are checked to be in working order on a regular basis.	Provide evidence that a formalised process is in place to ensure all call bells are checked on a regular basis. 180 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Moderate	All surveillance information is collated at the end of each month. Short term plans were evident as was the infection summary in each of the resident's files. It was evident from staff interviewed that they knew the residents well and were able to identify the residents that frequently have infections and the interventions required specifically for that resident. Family/whanau interviewed stated that they were happy with the	Infection control surveillance results are not identified and being shared in caregiver and registered staff meetings. Also refer to comments in criterion 1.3.5.2.	Provide evidence that surveillance results are shared with all staff in a timely manner.

		care and communication provided. At the time of audit, three residents were highlighted as residents with frequent infections. In three files of seven residents reviewed, all relevant information was highlighted in interRAI, but this information was not reflected in their long-term care plans evidencing the frequency of infections nor interventions required to minimise and reduce the risk of re occurrence (see criterion 1.3.5.2). Review of staff meetings did not show evidence that infections were always discussed in registered nurse and care staff meetings and this was also identified in care staff interviews.		60 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the</p>	PA Low	All residents with enablers and restraint had restraint monitoring forms which had been developed according to identified level of risk to the resident. The timeframes for each monitoring episode for all residents were clearly documented as two hourly. This timeframe was not being met. Staff said they were checking residents at least two hourly but that they did not always document this. There were no documented incidents around restraint to show that restraints were not being used safely.	Two restraints in the restraint register were documented as enablers, but do not comply with being voluntary and are clearly restraints.	<p>Provide evidence that the restraint register accurately records the type of restraint being used, and if it is a restraint or an enabler, as identified in policy.</p> <p>180 days</p>

evaluation of the restraint.				
<p>Criterion 2.2.3.5</p> <p>A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.</p>	PA Low	<p>The service has a restraint register in use which identifies all restraint and enablers in use. The information is not accurately recorded as two restraints were documented as enablers. The restraint coordinator did not clearly understand the difference between a restraint and an enabler although they have undertaken appropriate education. As enablers and restraint monitoring requirements are the same and undertaken according to identified risks, there is no reason to believe that restraint use is unsafe.</p>	<p>Two restraints in the restraint register were documented as enablers, but do not comply with being voluntary and are clearly restraints.</p>	<p>Provide evidence that the restraint register accurately records the type of restraint being used, and if it is a restraint or an enabler, as identified in policy.</p> <p>180 days</p>

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

No data to display

End of the report.