

# Ruapehu Masonic Association Trust - Masonic Court Rest Home

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## 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:** Ruapehu Masonic Association Trust

**Premises audited:** Masonic Court Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 27 February 2018      End date: 28 February 2018

**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:** 36



# Executive summary of the audit

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## 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

Masonic Court rest home provides rest home level of care for up to 56 residents. On the day of the audit there were 36 residents.

Masonic Court rest home is governed by a Trust Board. The facility manager has been in the role two and a half years and is responsible for the daily operations for the facility. She is supported by a full-time clinical nurse leader. Residents and family interviewed were complimentary of the service they receive.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

This audit identified an improvement required around neurological observations.

A continuous improvement rating has been awarded around a quality project.

## 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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The staff at Masonic Court rest home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Masonic Court rest home has a documented quality and risk management system. Quality management processes are reflected in the quality improvement plan's objectives and goals. Quality data is collated for infections, accident/incidents, concerns and complaints and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



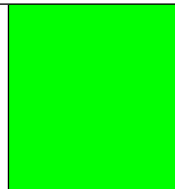
Standards applicable to this service fully attained.

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. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies.

The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner. The diversional therapist and activities assistant provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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



Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms have ensuite toilets or full ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. A civil defence/emergency plan is documented for the service. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint should this be required. At the time of the audit there were no restraints or enablers in use.

## 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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	1	91	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with nine care staff (one registered nurse (RN), six caregivers, one cook and one diversional therapist) confirmed their familiarity with the Code. Six residents and seven family members interviewed confirmed the services being provided are in line with the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the six residents' files. Advanced directives if known were on the residents' files. Resuscitation plans for competent residents were appropriately signed. 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. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided. Long-term resident files reviewed had a signed admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services.
<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>	FA	Residents and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. Entertainers are regularly invited to perform at the facility.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of any concerns/complaints in consultation with the RN for clinical concerns/complaints. Complaint forms are visible throughout the facility. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. There have been two complaints made in 2017 since the last audit. The documentation for each complaint shows investigation and actions taken for resolution to the satisfaction of the complainant.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission a manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. House rules are signed by staff at commencement of

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>employment. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Abuse and neglect training was last provided in October 2017.</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>The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there were no residents that identified as Māori. A member of staff is a Kaumātua and is able to offer guidance on cultural awareness. Discussions with staff confirm that they are aware of the need to respond with appropriate cultural safety.</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>Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-service training. The facility manager and clinical nurse leader share the responsibility for coordinating the internal audit programme. Monthly staff and quarterly quality meetings and monthly residents' meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by the facility manager, clinical nurse leader and the RNs.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Five residents and four relatives confirmed on interview that the staff and management are approachable and available. Twelve accident/incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any accident/incidents. Families are invited to attend the monthly resident/family meetings. Interpreter services are available as required.</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>	FA	<p>Masonic Court rest home provides care for up to 56 rest home level of care residents. On the day of audit there were 36 residents, which included one resident on respite, two on an intermediate care DHB contract and one on a non-weight bearing DHB contract. All other residents were on the aged related residential care (ARRC) contract.</p> <p>Masonic Court rest home is governed by a Trust of nine board members with a range of experience and skills including clinical expertise. Masonic Court's philosophy and values flow from the principles of the freemasonry and underpins the business plan, quality goals and objectives. The 2018 quality improvement plan included objectives and goals to set by the Masonic Court rest home quality improvement committee. The quality improvement plan for 2017 has been reviewed quarterly (sighted) and reported to the board of trustees.</p> <p>The facility manager (non-clinical) works full-time and has been in the position for two and a half years. She has 17 years' experience in healthcare management. The facility manager is supported by a clinical nurse leader. The clinical nurse leader has been in the position since July 2017. He has previous experience as a nurse supervisor and clinical quality coordinator.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The facility manager and clinical nurse leader have access to a regional aged care education/consultant.</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</p>	FA	<p>The facility manager reported that in the event of her temporary absence the clinical nurse leader fills the role with support from the RNs and other care staff.</p>

<p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>Masonic Court rest home has a documented quality and risk management system. Quality management processes are reflected in the quality improvement plan's objectives and goals. The facility managers' monthly report to the board of trustees covers staffing, resident occupancy, quality improvement activities, accident/incident data, audits (internal and external) and any complaints/compliments. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are up-to-date and are reviewed two-yearly. Staff interviewed confirmed they are made aware of new/reviewed policies.</p> <p>Staff interviewed confirmed they are aware of the results of internal audits, health and safety and infection control data, trends and corrective actions, new or reviewed policies and procedures. Infection control, health and safety, management and general staff meetings are held regularly. Data is collected in relation to a variety of quality activities and internal audits are completed as scheduled and include environmental, infection control, organisational and clinical audits including quarterly medication audits. Areas of non-compliance identified through quality activities are actioned for improvement. Meeting minutes and quality data is available for staff.</p> <p>There is a health and safety and risk management system in place including policies to guide practice. The service has a health and safety committee with specific role responsibilities. The health and safety officer (caregiver) has completed the specific health and safety training. Hazard identification forms and a current hazard register are in place. Fall prevention strategies are in place that include the analysis of falls accident/incidents and the identification of interventions on a case-by-case basis to minimise future falls. Resident satisfaction survey (August 2017) and family satisfaction survey (October 2017) have been collated. The resident satisfaction survey had a 90% satisfaction result and the family satisfaction survey had an 85% satisfaction result of either excellent or very good. Results have been fed back to participants.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected</p>	<p>PA Low</p>	<p>There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of February 2018 were reviewed. All document timely RN review and follow-up. However, neurological observations were not fully completed for five resident falls that resulted in a potential head injury. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been one section 31 notification lodged</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>for an unstageable pressure injury since the last 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>There are human resources policies to support recruitment practices. Seven staff files (one facility manager, one clinical nurse leader, one RN, three caregivers and one recreational officer) were reviewed. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Annual performance appraisals were current. Current practising certificates were sighted for the RNs.</p> <p>The clinical nurse leader has completed interRAI training and the two RNs were due to start interRAI training. The service has an orientation programme in place to provide new staff with relevant information for safe work practice. The RNs and caregivers' complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period.</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>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are always two care staff on duty 24 hours a day, seven days a week. The facility manager and clinical nurse leader both work 40 hours per week Monday to Friday and are available on call 24/7. The clinical nurse leader is supported by RNs who works from Monday to Sunday 7.30 am to 4.00 pm.</p> <p>The RN is supported by four caregivers (two long and two short shifts) on the morning shift and three caregivers (two long and one short shift) on the afternoon shift, and two caregivers on the night shift. Caregivers interviewed confirmed the RNs are readily available after hours. The rosters sighted confirmed that staff are replaced on the roster. Resident acuity is monitored, and additional staff are available to assist with more dependant residents. There are dedicated activity, cleaning, laundry and food services staff. Interviews with residents and family identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.</p>

when required.		
<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>	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for long-term care or short-term care are provided for families and residents prior to admission or on entry to the service. The service also has a web site. All admission agreements reviewed (for three long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.
<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	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were 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 were involved for all exits or discharges to and from the service.
<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	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were four residents self-medicating on the day of audit. Self-medication competencies had been reviewed three-monthly. Twelve medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round.
<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>All meals are prepared and cooked on-site. There are two cooks (one is also kitchen supervisor) and four kitchenhands employed. Food services staff have attended food safety and chemical safety training. The menu has been reviewed by a dietitian. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Special diets are accommodated including allergies and modified food textures. Individual breakfast trays have individual teapots, each with a brightly knitted tea cosy. Resident's interviewed like this homely touch.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A</p>

		<p>maintenance and cleaning schedule is maintained. Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes. The service received an A Rating for their kitchen under their Food Safety Plan verification.</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>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. InterRAI assessments are completed six monthly or earlier due to health changes. Paper-based assessments such as falls, pain, continence (as examples) were also used. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans reviewed were resident focused and individualised. New templates were clear and included reference to a wide range of resident holistic needs. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files, for example, pain, infections and wounds, and have either been resolved or if ongoing, transferred to the long-term care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process.</p> <p>Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The residents on short-term contracts (respite care, intermediate care and non-weight bearing) had all identified needs included in the short-stay support plan with short-term care plans for acute needs. There was evidence of allied healthcare professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.</p>



<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, a RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file, that family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Two residents with weight loss had documented intervention of high protein drinks and snacks.</p> <p>The GP was aware of both resident's weight loss. Adequate dressing supplies were sighted in the treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds. District nurse and wound specialist review were documented for chronic wounds and pressure injuries. The service has three residents with a pressure injury at the time of audit (one unstageable, and two grade two). All had documented wound assessments, plans and evaluations and all were improving. Ten current wounds were reviewed. All had an assessment, management plan and evaluations.</p> <p>The service has introduced new wound management templates, and these were observed to be clear and well documented. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour and food and fluid charts (link to 1.2.4.3 for neurological observations).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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 service employs two diversional therapists (DT) that works Monday – Sunday. They are supported by an activity assistant on Mondays and occasionally on Sundays. The programme is seven days a week and integrated to meet the physical and psychosocial well-being of the residents. There are regular outings into the community. The service has a van for regular outings. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The varied programme includes guest speakers, charity high teas so that residents can donate to charity of their choice.</p> <p>Bingo, crafts, reminiscing, inter-home games, and craft groups are some of the activities on offer. A diversional therapy resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The DT is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through two monthly resident</p>

		meetings and direct feedback from residents and families. Residents interviewed spoke very positively about the varied activities programme which they have input in.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes in the long-term files reviewed. Written evaluations reviewed on the care plan identified progress towards goals. Short stay residents are evaluated daily. Family had been invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
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 to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff and posted on the wall in the laundry. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building has a current building warrant of fitness that expires 3 August 2018. There are three maintenance staff who between them undertake preventative and reactive maintenance and grounds management. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical

for their purpose.		equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. The outside area for residents is well designed and appropriate for residents who like to go outside. The caregivers and RNs stated they have sufficient equipment to safely deliver the care and support as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are sufficient communal showers and toilets to meet the needs of the residents in both wings. Hand basins, toilets and shower facilities are of an appropriate design. The communal toilets and showers have privacy locks. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal care.
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	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large recreation area where most group activities take place. The service has a large lounge and a large dining area as well as smaller quiet lounges, and several smaller seating areas. All communal areas are accessible to residents. Caregivers assist to transfer residents to communal areas for dining and activities as required. The service has recently created a small sensory room. This room is a quiet, relaxing area that has been popular with both residents and village residents.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry staff on duty five days a week and cleaning staff on duty seven days a week. All laundry is completed on-site. The laundry staff have completed chemical safety training and laundry processes. The laundry has a designated dirty to clean flow

<p>appropriate to the setting in which the service is being provided.</p>		<p>which the laundry person was able to explain. There is appropriate personal protective-wear readily available. The cleaners' trolleys are stored in a locked area when not in use. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 15 August 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, a generator, and gas cooking.</p> <p>Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. All RNs hold a current first aid certificate. There is a new call bell system in place and there are call bells in the residents' rooms, and lounge/dining room areas. Call bells have display boards in all corridors and the nurse's station. The facility manager reports that the new call bell system has reduced the time for call bell answering, which is closely monitored by the service. Residents were observed to have their call bells in close proximity (link quality project 1.2.3.6).</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>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed temperatures are comfortable.</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</p>	<p>FA</p>	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A RN (clinical nurse leader) is the designated infection control coordinator with support from other members of the infection control team. Infection control is reported monthly to the quality meeting and there are quarterly infection control meetings. Minutes are available for staff. Internal audits have been conducted and include hand hygiene and infection control practices. Education is</p>

the size and scope of the service.		provided for all new staff on orientation. The infection control programme has been reviewed annually.
<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	A RN is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have external support from the IC nurse specialist at the DHB. 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.
<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	The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has attended training through Bug Control. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually.

<p>specified in the infection control programme.</p>		<p>Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and clinical nurse leader. One outbreak during November 2017 (Norovirus) has been effectively managed. Notification was made to public health and the DHB.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The facility is restraint free. An RN oversees the enabler/restraint process within the facility. There were no residents on restraint and no residents using an enabler at the time of the audit. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of February 2018 were reviewed. All document timely RN review and follow-up. However, neurological observations were not fully completed for five resident falls that resulted in a potential head injury.	Twelve accident/incident forms were reviewed in total. Eight of the twelve accident/incident forms reviewed were for resident unwitnessed falls with a potential head injury. For four of the eight unwitnessed falls with a potential head injury incident, the neurological observations were not fully completed as per the policy requirement.	<p>Ensure that neurological observation forms are fully completed for any resident fall with a head injury as per the policy requirement.</p> <p>90 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, 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
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Each week a chart is published documenting average call-bell answer times. It was identified that call bells were taking a long time to be answered and therefore the service implemented a quality project to address this.</p>	<p>The service has implementing quality projects as a follow up from data being collected. Following discussion and a business case to the board the service introduced the following. It was identified that the current call bell system that used staff pagers was not ensuring prompt answering of bells. A new call bell system was purchased. This new call bell system has display boards in all wings and communal areas. The nurse’s station and managers office have a computer screen identifying all calls. The computer screens have allowed the management team to oversee all calls and monitor call bell answer times at the time of the call.</p> <p>Discussions were held with staff regarding the importance of call bell answering. Each week a poster is displayed showing call bell answer times. Observation of staff over the two-day audit evidenced that they monitor themselves and ensure that call bells are answered. During February 2017, 19% to 30 % call bells took over 10 minutes to answer. During February 2018, this has fallen to 3% to 4.4%. Residents interviewed said the call bells were answered well</p>



End of the report.