

Metlifecare Limited - Greenwich Gardens Care Home

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:	Metlifecare Limited
Premises audited:	Greenwich Gardens Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 May 2018 End date: 24 May 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:	43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Metlifecare Greenwich Gardens Care Home (Greenwich Gardens) provides rest home and hospital level care for up to 48 residents. The service is operated by Metlifecare Limited and clinical services are managed by a nurse manager who has been in the role since the care home was being built and was opened in July 2017. The nurse manager reports to the village manager who takes overall responsibility for all services offered at the facility. The clinical quality and risk manager from Metlifecare senior management team supported the nurse manager on the days of audit. 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, management, staff, contracted allied health providers (the physiotherapist and occupational therapist) and a general practitioner.

This audit has resulted in three areas of continuous improvement related to continuity of service delivery, falls management and nutrition. No areas were identified for improvements.

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 interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and 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 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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals and values of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management 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. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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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 and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. Residents can access all village facilities. There is a current code of compliance. Electrical and medical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. Policy and procedures include a comprehensive assessment, approval and monitoring process with regular reviews should restraint be implemented. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. All clinical staff have attended restraint education in the last 12 months.

Infection prevention and control

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

Standards applicable to this service fully attained.

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The organisation 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 is 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

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</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.</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. There are different inside and outside areas of the facility that residents with visitors can utilise, other than their bedrooms.</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 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. Information is on display at the entrance to the facility.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year. For three of the complaints actions taken, through to an agreed resolution, are documented and completed within the timeframes. One complaint received in May 2018 remains open, but actions taken to date are documented with a family meeting organised. Action plans show any required follow up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous 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 discussion with staff. The Code is displayed in the main areas together with information on advocacy services, how to make a complaint and feedback forms.</p>

<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>	<p>FA</p>	<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 and/or share a room with their spouse with their consent.</p> <p>Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing, and choosing from the meal plan. 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>	<p>FA</p>	<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. The senior registered nurse interviewed reported that there are currently no residents who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. There is a specific current Māori health plan, and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and integrated into long-term care plans with input from cultural advisers within the local community as required. With the resident's consent a referral form is completed and sent to the local rohe for ongoing support. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</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>	<p>FA</p>	<p>Residents interviewed 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.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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 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 general practitioner (GP) confirmed 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>Other examples of good practice observed during the audit included the knocking on resident's doors before entering and general day to day conversations observed at the time of audit.</p>
<p>Standard 1.1.9: Communication 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. Throughout the facility there are suggestion boxes with feedback forms to support compliments and complaints and this information is also provided in information packs to new residents and their families. The noticeboard in the residents' lounge/dining area provided contact details for the supporting advocate, telephone interpreting services and local iwi contact specific to the facility's local community.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There are five residents residing at the facility who have a significant sensory loss. Specialised equipment and community support services have been provided to encourage and maintain their independence and external support.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>The organisation and site specific strategic and business plans, which are reviewed annually,</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of quarterly reports to the senior clinical management group who report to the board of directors showed adequate information to monitor performance is reported including financial performance, quality outcomes, emerging risks and issues.</p> <p>The service is managed by a nurse manager who has a current annual practising certificate and holds relevant qualifications and is experienced in aged care. The nurse manager has been in the role for 13 months. The nurse manager reports directly to the village manager who has overall responsibility for services provided and has been in the role for over three years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager and village manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through ongoing education in clinical and management sectors.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with Waitemata District Health Board for respite, hospital, medical and rest home level care. All 43 residents were receiving services under the ARRC contract (23 rest home level care and 20 hospital level care) at the time of audit.</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 provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the village manager is away, the village coordinator and nurse manager undertake this role. When the nurse manager is away the role is covered by a senior registered nurse who carries out all the required duties under delegated authority with support from the village manager and the clinical quality and risk manager from the Metlifecare senior management team. All the above-named staff are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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, infection control benchmarking, an annual resident/family satisfaction survey undertaken by an independent company, monitoring of outcomes, clinical incidents including infections, wounds, pressure injuries and falls.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the head of departments meetings, management/quality and risk team meetings and staff meetings. Reports presented at the meetings include infection control, health and safety, restraint, activities, complaints, audits,</p>

		<p>resident directed care, staff education, clinical indicators, projects and initiatives and incident and accident data.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, involvement in projects and initiatives and implementation and reporting of outcomes for corrective actions put in place. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed by an independent company annually. The facility was opened in June 2017 and 2018 results were not yet available at the time of audit. However, any issues raised by residents are addressed promptly as identified in documentation sighted and confirmed during resident and family interviews. One example identified education being put in place for contracted staff to ensure they maintain a high standard of communication with residents when they are providing cares.</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 based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff can access policies and procedures electronically and in hard copy. All policies sighted at the facility were current.</p> <p>The nurse manager and members of the health and safety committee described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both the village manager and nurse manager are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</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. Adverse event data is collated, analysed, reviewed daily by the senior registered nurse and reported to the nurse manager. Incidents and accidents are recorded electronically and discussed at two monthly senior management meetings and information is shared at board level as appropriate.</p> <p>The nurse manager and clinical quality and risk manager described essential notification reporting requirements, including for pressure injuries. This information is clearly set out in policy. They advised there have been five section 31 notifications to the Ministry of Health. Four related to pressure injuries (three non-facility acquired), and one related to a sudden death. The coroner's inquest confirmed that Greenwich Gardens are not an interested party to the investigation and this has been closed for the facility. Notifications for a gastrointestinal outbreak was notified to public</p>

		<p>health in August 2017.</p> <p>There have been no police investigations or issues-based audits.</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>	FA	<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 a three-month period. Annual staff appraisals are up to date.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or are about to commence a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are six trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the care unit.</p> <p>The nurse manager works Monday to Friday 8.30am to 5pm and is on call. The senior registered nurse works five days a week covering Tuesday to Saturday (8-hour shifts) and is on call. Laundry and cleaning staff cover seven days a week. Activities are undertaken Monday to Friday 8am to 4.30pm. The receptionist works 9am to 5.30pm Monday to Friday. Staff in the care facility do not</p>

		respond to village call bells as the village have dedicated staff who do this. Maintenance and kitchen staff are employed by the village but work across both the village and the care unit. There is a contracted physiotherapist and occupational therapist who work regular hours and on call at the facility.
<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>	FA	<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 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>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) 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 the NASC and GP 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 (see criterion 1.3.3.4). Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<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 the use of the yellow transfer form and supporting documents and communication between the GP,</p>

		care home, hospital and family. Family of the resident reported being kept well informed during the transfer of their relative.
<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 with the last controlled drug audit completed 31 December 2017.</p> <p>The records of temperatures for the medicine and separate specimen fridge and the medication room reviewed were within the recommended range. The facility offers flu vaccines; however, all vaccines are provided by an external source and no vaccines are stored on site.</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 was consistently recorded on the medicine chart. The facility does not use standing orders.</p> <p>There were four residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</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</p>	FA	<p>The food service is provided on site by a food services manager and is in line with recognised nutritional guidelines for older people. The menu provided is seasonal (currently autumn) and was last reviewed by a qualified dietitian in March 2018. Recommendations made at that time have been implemented.</p>

<p>this service is a component of service delivery.</p>		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and was graded an A passing with percentage of 97. Registration was issued by the Auckland Council and expires 9 May 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has 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 kitchen manager visits the resident at the time of admission and provides ongoing support as required. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews and resident 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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. 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</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<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 information. All residents have current interRAI assessments completed by one of six trained interRAI assessors on site with one registered nurse booked to commence training in July 2018. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied</p>

<p>promote continuity of service delivery.</p>		<p>health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is very good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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 activities programme is provided by an activities co-ordinator (whom is currently away on extended leave). The programme is currently overseen and supported by an occupational therapist who visits the facility weekly and supports the care staff and supporting bureau staff member who has prior experience as an activities co-ordinator and supports the residents Monday to Friday 7 hours a day.</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. The facility encourages the socialising of all residents (rest home and hospital level care) in the care home and village with activities often integrated and supported in both areas of the village and community outings offered. The facility's activities programme is also initiated and supported by regular volunteers some of whom reside in the village and care home providing support with the activities provided.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. A copy of the activities calendar is provided to each pod unit and a copy is also provided to each resident in large print. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme excellent.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<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 an 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>	<p>FA</p>	<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 GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to dietician, physiotherapist and wound nurse specialist. 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>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals have completed chemical safety education. An external company is contracted to supply and manage all chemicals and cleaning products and they provide relevant training for staff. 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 and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>A current code of compliance (expiry date 21 May 2019) 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 (17 May 2018) and calibration of bio medical equipment (16 November 2017) is current as confirmed in</p>

<p>for their purpose.</p>		<p>documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. There is very good storage at the facility which assists in keeping walking areas clear at all times.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they are happy with the environment and that maintenance is undertaken promptly as required.</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 two large bathrooms which allow shower trolleys to be used and every bedroom has full ensuite facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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 group and setting.</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. There are rooms available with adjoining doors for couples to use. At the time of audit two couples were at the facility. One couple use one room as a bedroom and the adjoining room as their lounge area and the other couple use the individual adjoining rooms as bedrooms with the door kept open. These residents report that the adjoining rooms work very well for them. Rooms are personalised with furnishings, photos and other personal items displayed. All bedroom doors are wide enough for beds and lifting equipment to be used.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. 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</p>	<p>FA</p>	<p>Numerous communal areas are available for residents to engage in activities. Each of the four 'pods' have dining and lounge areas which contain cooking facilities so that residents and families can share a meal at any time. Residents have full use of all village facilities. During the audit it was observed that care home residents made frequent use of the facilities available such as the café and the library areas. The dining and lounge areas are spacious and enable easy access for</p>

relaxation, activity, and dining needs.		residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.
<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>	FA	<p>Laundry is undertaken on site in a well-equipped laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The physical maintenance of the laundry equipment is contracted and checked regularly. The chemical mixes are monitored by the company who supply the chemicals to ensure correct usage is maintained for optimal cleanliness. A monthly report is sighted by the nurse manager.</p> <p>There is a small designated cleaning team who have received appropriate training. Cleaning and laundry staff have undertaken safe chemical handling education within the last year as confirmed during interview and in staff training records. Chemicals were stored securely and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through external checks by the chemical provider and the internal audit programme.</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>	FA	<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 described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 18 May 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 09 May 2018. No follow-up was required. 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 48 residents. Water storage tanks are located around the complex. Emergency lighting is regularly tested by an approved provider. As a learning from a near-by sister facility who recently had a power cut for several days, Greenwich Gardens has two additional disaster kits ready to go, should another facility require one for a longer than usual emergency.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. If a call bell is not responded to within four minutes, it is escalated to the senior RN pager. The nurse manager</p>

		<p>provided evidence that any call not responded to within 10 minutes is fully investigated. Investigation identified that the call bell was not being shown as responded to by staff when the staff member remained in the resident's bedroom and used the call bell to seek another staff member's assistance. This is being rectified by the company who installed the call bells. Residents are also offered personal pendants for their use which are also responded to by the same pager system.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the night porter and a security company make checks of the premises at night. CCTV operates at the care facility reception area and this is monitored at the village reception area.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and 23 bedrooms have ranch slider access to a balcony area. There is easy outdoor access from communal areas. Heating is provided by electric central heating with heat pumps in every room. 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>	FA	<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 GP, pharmacy and public health. The infection control programme and manual are reviewed annually.</p> <p>The senior 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 nurse manager, and tabled at the quality/risk committee meeting. This committee includes the nurse manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Signage is identified throughout the facility requesting 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</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been</p>

<p>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>		<p>in this role since June 2017. She has undertaken education in infection prevention and control as verified in training records sighted and is booked to attend upcoming relevant study days. 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 include 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 consumers.</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, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred with a gastro enteritis outbreak in August 2017.</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 hotter weather.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections.</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>The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers.</p> <p>The facility has had a total of 87 infections since October 2017. Two residents have been identified with 14 of the 87 infections due to co-morbidities. One resident has since deceased. The remaining residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Eighty-five percent of residents and 63 percent of staff consented and have had the flu vaccine this year. Data is benchmarked externally within the group and QPS three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak in August 2017 where five residents and one staff member were affected was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation 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. Greenwich Gardens is a restraint free environment with no enablers or restraints in use at the time of audit. This was confirmed by staff and in the restraint committee meeting minutes and staff meeting minutes. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. Staff training occurs annually and as part of new staff orientation as confirmed in staff files reviewed.</p> <p>Policy identifies that enablers are to be the least restrictive and used voluntarily at the resident's request following appropriate assessment with the intent of promoting independence, comfort and/or safety.</p> <p>The restraint coordinator confirmed that restraint would only be used as a last resort when all alternatives have been explored.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer</p>	CI	<p>In July 2017 it was identified that the facility would like to support residents to maintain their independence with food choices and decision making. This is also in line with the organisation’s vision which is ‘To provide quality innovative and sustainable solutions for the lifestyle and care needs of older people’ and also reflects one of the three strategic goals, which relate to the customer experience, the focus to significantly enhance the food and dining experience, and the optimizing of the whole ‘customer journey’. Menu sheets are provided to each resident daily, who are then supported to choose what they would like to eat for the following day. Breakfast consists of different cereals and condiments. There is the option of having a main meal at lunch or dinner and both meal times provide two meal options including different vegetables and deserts options. There is also the option of a soft diet and snack choices. A copy of the menu is then provided to residents, who if they have a memory impairment, are able to self-remind themselves what they have chosen, and visiting family members can also see what the resident has chosen to eat. The kitchen manager meets and greets all new residents and attends the residents’ meetings. The meals are provided from one of four pod kitchenettes and are set up to provide a ‘homely experience’. There has been positive feedback in residents’ meetings with residents and families interviewed stating that they were really happy with the food options provided, and that the menus were a ‘talking point’ when visiting. The staff interviewed stated that there is a lot less food wastage and the</p>	<p>The service is rated continuous improvement by encouraging residents to be supported to maintain their independence with choices in their nutritional needs and requirements.</p>

group.		nurse manager reporting that the total cost of the food monthly has been reduced by 20 percent from December 2017 to March 2018.	
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	CI	<p>In July of 2017 it was identified by staff that they did not have enough detailed relevant information about the resident prior to their admission to ensure that the care that was provided by staff was resident focussed care. A committee was developed to research different ideas and a staff meeting was held to brainstorm. A questionnaire was developed and provided to three relatives and three residents in September 2017 with the focus on the existing 'Know me – don't change' me booklet, which was part of the existing information pack, and highlights the resident's life story, hobbies and interests. As a result, this booklet has been reviewed and now includes the question 'My life now', a question that both residents and families reported as being more relevant to them and what they wanted staff to know. A summary of this book was then developed for each resident under the headings 'My morning, my afternoon and my night'. This summary is a working document and all staff are encouraged to update on a regular basis. A questionnaire was developed and provided to six staff to review the effectiveness of this summary, the response from the staff was positive.</p> <p>The facility has also, as part of the information pack, created an individual admission letter that is addressed specifically to the resident being admitted. The letter includes information such as the names of the key registered nurse and caregivers that will be supporting the resident on the day of admission and also invites a family member of the resident to stay the initial night and have a meal to support the transition of the resident into the facility.</p> <p>In July of 2017 it was identified by staff that they would like to be more accessible and visual to residents. This issue raised was also initiated due to the organisation's vision of 'a paper-less resident record system'. The facility supports 'four pods' or areas that each support 12 residents. There is no identified nurses' station, however each pod has an open work station with access to a laptop (stored securely when not in use). This allows residents and families to have visual access to staff at all times and for staff to remain in the area and be accessible while completing their documentation. An electronic system has been implemented to create a paperless system which supports all staff including allied staff to complete progress notes and visits as situations arise and have quick access to accumulated data, for example, resident's weights and observations and incidents. Long term care plans and evaluations and wound care management are also electronic; however, staff do have access to a paper copy in the resident's file. The facility has provided tiered mobile tables that support the use of laptops to be used and/or accessed, for example, while wound dressings and the taking of observations occur. A verbal, paper and electronic walking handover occurs which involves a visual check of each resident. The ease and accessibility of the mobile tables and laptop supports increased satisfaction and productivity by also identifying electronically tasks that are required by staff for that shift. There have been two questionnaires provided to staff facilitated by information technology staff (IT) with initial and updated training provided to all staff which</p>	<p>The service has implemented two areas of continuous improvement by demonstrating an ongoing review process and increased resident and staff satisfaction with the support and information provided to new residents and their family on admission and the implementation of the paperless system to support a team approach and improved service delivery.</p>

		includes education around the electronic device and the ensuring of privacy of residents' information. Training is also included in staff orientation. A third questionnaire by IT for staff was completed in March 2018 and shows staff satisfaction. Issues raised such as the need to have 24-hour IT support and the security risk around allied support signing in and out are being currently addressed.	
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	CI	<p>It was identified that between August and December of 2017 that there was an increase in falls. A total of 45 falls were documented with 10 residents in particular having had two or more falls in the prior four weeks. Results also found that there were 14 falls between the hours of 3 pm and 5 pm and 11 falls between the hours of 3pm and 4 pm. 34 of the 45 falls occurred in residents' bedrooms and results also highlighted an increase in falls between September and November on a Sunday and Wednesday. As a result, a corrective action was developed in December of 2017 and interventions were put in to place which included a review of all long-term care plans and equipment. All residents identified were reviewed by the physiotherapist, and the gerontology nurse specialist was also involved. The visual staff handover and use of privacy curtains in resident's bedrooms were also reviewed for individual residents. Discreet high fall (shooting star) signs were placed on the relevant residents' doors and the same shooting stars sign was also placed on the wall by the resident's bed to guide and ensure staff leave the resident's bed at the right height for the resident. An evaluation in January 2018 found that between 3pm and 6 pm falls were reduced from 16 to 5. Another evaluation in February of 2018 found that the number of falls had not reduced, however found that three of the 10 residents last fell in October 2017 and two of the 10 residents last fell in November and December. The facility investigated further to see if there was a correlation related to falls occurring on a Sunday and Wednesday, however no contributing factors were identified and subsequently were not highlighted as an issue again in further reviews. The facility continues to focus on reducing falls.</p>	<p>The service is rated as continuous improvement by demonstrating an ongoing review process and increased individual resident safety for falls.</p>

End of the report.