

Rangiura Trust Board - Rangiura Rest Home & Retirement Village

Introduction

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

The audit has been conducted by 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:

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| Legal entity: | Rangiura Trust Board |
| Premises audited: | Rangiura Rest Home & Retirement Village |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 16 August 2018 End date: 17 August 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: | 74 |

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 |
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|  | 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 |
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| | 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

Rangiura Rest Home and Retirement Village (Rangiura Home) provides rest home, dementia and hospital level care for up to 81 residents. The service is operated by Rangiura Trust Board and managed by a general manager with support from two clinical leads. An acting general manager has been in place since June this year. A new policy and procedure system is being introduced.

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, the nurse practitioner and a general practitioner. Residents and families spoke positively about the care provided

This audit has resulted in nine areas requiring improvement in relation to staffing, performance appraisals, assessment, planning, activities, food storage, chemicals and restraint documentation.

Consumer rights

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| 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 support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and 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

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. 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 is used to identify and deliver ongoing training. 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

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| <p>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.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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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, general practitioner and/or nurse practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information. 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. Residents verified satisfaction with meals.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. 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. Communal and individual spaces are maintained at a comfortable temperature

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Some standards applicable to this service partially attained and of low risk. |
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The organisation has implemented policies and procedures that support the minimisation of restraint. Seven enablers and eight restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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| 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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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) |
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| Standards | 0 | 41 | 0 | 4 | 5 | 0 | 0 |
| Criteria | 0 | 92 | 0 | 4 | 5 | 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) |
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| 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed 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 and were evidenced in all residents' files reviewed, including enacted enduring power of attorney documents for the five residents' files reviewed residing in the dementia unit. Staff were observed to gain consent for day to day care. |

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| <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> | <p>FA</p> | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The diversional therapist interviewed stated that the residents' meetings are facilitated by an external person from the local community.</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. The facility has lounges and different sitting areas inside and out that families can access when visiting. There is also a whanau room with kitchenette available.</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 what to do if they had concerns.</p> <p>The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The GM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There 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/agreement provided and discussions with staff. The Code is displayed in several areas of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p> |

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| <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.</p> <p>Residents are encouraged to maintain their independence by attending, community activities, participation in clubs of their choosing and going out with family. 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 whānau. The clinical nurse administrator interviewed reported that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who identify as Māori. There is a specific current Māori assessment health plan, all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced throughout the residents long-term care plans. Support is available from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Whanau were not available for interview, however the Māori resident interviewed reported that staff acknowledged and respected their individual cultural needs.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met and there is an increase in resident satisfaction.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p> | <p>FA</p> | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes</p> |

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| discrimination, coercion, harassment, sexual, financial, or other exploitation. | | 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. |
| Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard. | FA | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the 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) and nurse practitioner (NP) 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 doors before entering residents' rooms and observations of day to day discussions between staff, residents and family members.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the use of family members. There were four residents identified who had a significant sensory impairment and appropriate resources and equipment were observed to support the resident which included the use of a talking books, updated hearing aids and support from the hearing association to assist with communication.</p> |
| Standard 1.2.1: Governance The governing body of the organisation ensures services | FA | Rangiura Rest Home is operated by the Rangiura Trust Board who also operate a retirement village on the same site in Putaruru. The Trust Board was established in 1978 and the Rest Home opened in 1981. The service holds contracts with Waikato District Health Board for respite, rest home and hospital |

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| <p>are planned, coordinated, and appropriate to the needs of consumers.</p> | | <p>(geriatric) care up to a maximum of 81 residents. At the time of audit there were 74 residents receiving services under the contract. Twenty three were assessed as requiring hospital level care, 34 as rest home (including four respite) and 15 residents were in the dementia unit. There were no residents under the age of 65 years. People living in the village do not receive care services.</p> <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board showed adequate information to monitor performance is reported including financial performance, emerging risks and issues. Rangiura is part of the Community Trust Care Association (CTCA) group. CTCA is a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations.</p> <p>The service is currently overseen by an acting GM who holds relevant qualifications and has been in the role for six weeks. The organisation is currently recruiting for a permanent replacement. Responsibilities and accountabilities for the role are defined in a job description. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through engagement with the aged care sector and by attending conferences and training.</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 GM is absent, the role is shared between senior staff and the chairperson of the Trust. The two clinical leaders cover for each other and any other absent RNs. Both clinical leaders 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</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, reporting and tracking of infections and restraint events, scheduled internal audits, regular resident and relative satisfaction survey and monitoring of outcomes.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at a variety of management team, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and feedback from quality analysis. Graphs showing the prevalence of falls and when</p> |

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| <p>principles.</p> | | <p>these occur are displayed in the staff room. Quality data was being benchmarked with the eight other age care facilities in the CTCA group; this is now being benchmarked with a much larger nationwide group. Where necessary corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey revealed a lower (62%) than national average (80%) rating for food services. Immediate actions have been taken to improve food services, such as appointing a new food services manager, and reviewing and amending the menus. The feedback from family and residents has improved.</p> <p>The policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM understands the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Staff and the manager are familiar with the Health and Safety at Work Act (2015). A dedicated health and safety team under the guidance of a health and safety coordinator work to meet the requirements. There have been no reports to Worksafe NZ in this audit period.</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>A new system for reporting accident/incidents was introduced in June. All adverse and near miss events are entered in to an electronic system which immediately alerts the GM, clinical leaders and the chairperson of the trust if the level of risk is critical or major. The new system collates the most common time and place of events, allowing quick analysis for trending. Summary of the past two months show falls make up the majority of events, and that these occur in resident's bedrooms between 11am and 4pm. Preventative measures such as half hourly monitoring and pre-emptive toileting at peak times have been instigated. A sample of incidents forms reviewed showed who had been notified, that the incidents were being investigated, and that actions are being followed-up in a timely manner. All adverse event data is collated, analysed and reported to the board and all staff at their monthly meetings. The data is also being benchmarked nationally.</p> <p>The GM understands essential notification reporting requirements, including for pressure injuries. There have been two notifications of significant events made to the Ministry of Health, since the previous audit. Both were police investigations related to an intruder and theft on site. Two out breaks of norovirus were reported to public health in September 2017 and May 2018. The September outbreak affected more residents and staff than the May outbreak which was contained within seven days.</p> |

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| <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>PA Low</p> | <p>Staff 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 showed documentation of completed orientation followed by an initial performance review. Annual performance appraisals are overdue.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated completion of the required training. Only care staff who are progressing or have achieved level 4 qualifications are rostered on for work in the dementia unit. The clinical leaders are maintaining annual competency requirements to undertake interRAI assessments. Four other staff including an EN and the physiotherapist have completed their interRAI training.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>PA Moderate</p> | <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. Observations and review of a four-week roster cycle confirmed adequate staff cover in all areas is being provided, but an improvement is required concerning the whereabouts of staff in the dementia unit and at shift handover times. Current staffing levels are safe, as determined by the acuity of residents against the EAP formula. On the week of audit there were 392 hours of RNs and 1321.5 hours of health care assistants per week. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported their workload as heavy but said there were adequate staff available to complete the work allocated and that staff were replaced in the event of absences. Residents and family interviewed supported this. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and</p> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP/NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> |

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| accessible when required. | | <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 (DSL) Service. Residents requiring dementia level care have been assessed by a specialist. 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 DSL, and the GP/NP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Admissions agreements were sighted for residents admitted to the dementia unit, the files reviewed had their admission agreements signed by the residents enacted enduring power of attorney. 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 required documentation and communication between the facility, resident's family, ambulance service and acute hospital setting. Family of the resident reported being kept well informed during the transfer of their relative.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</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 a paper-based system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines</p> |

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| <p>requirements and safe practice guidelines.</p> | | <p>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 on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>PA Moderate</p> | <p>The food service is provided on site by a cook who has been employed for five months and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. A new menu has been introduced to the facility and was reviewed by a qualified dietitian in August of 2018. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines, with the exception of some food sighted which was not stored and labelled appropriately. The service has a food safety plan and is currently utilising the generic food care plan templates. The facility is registered with the South Waikato District Council and the certificate has expired in June 2018. Email communications sighted showed evidence that payment has been made by the facility in March 2018 and this has been acknowledged by the council, however the facility is still awaiting an updated registered certificate and visit from the council to approve the current food plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook 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 personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit</p> |

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| | | <p>have access to food and fluids to meet their nutritional needs, at all times. Special equipment, to meet resident's needs, is available.</p> <p>Evidence of increased resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes (see standard 1.2.3). Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The health care assistant was observed prior to lunch in the main dining room ringing a bell and informing/reminding residents of the meal been provided, activities for the day and ended with a prayer.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local DSL is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the DSL is made and a new placement found, in consultation with the resident and whānau/family; however, this is not always occurring as needed (please see criterion 1.3.4.2). 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> | PA Moderate | <p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, and nutritional screening, 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, except for one assessment in draft, have current up to date interRAI assessments completed by one of six trained interRAI assessors on site. This includes the clinical nurse leader, clinical nurse administrator and physiotherapist. Residents and families confirmed their involvement in the assessment process. At the time of audit two residents in the dementia unit and one resident in the rest home are requiring two staff to assist for all daily activities of living and mobility. Also noted was one resident in the dementia unit who is acutely unwell and currently also requires two staff to assist for all daily activities of living and mobility and transfers.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote</p> | PA Moderate | <p>Care plans evidence service integration with progress notes, activities notes, medical and allied 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. The five residents files reviewed in the dementia unit had behaviour management plans integrated throughout the long term care plans that included</p> |

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| <p>continuity of service delivery.</p> | | <p>triggers and interventions for behaviours but this information was not identified over a 24 hour clock period (see criterion 1.3.7.1).</p> <p>Short and long-term care plans reviewed did not always reflect the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs of the residents were not always identified in the interRAI assessments and then reflected in care plans reviewed (see also criterion 2.2.1).</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>Interviews with staff verified the provision of care provided to residents was consistent with their needs, goals and verbalised plan of care that occurred in handover, but information was not always outlined in the documentation (see criterion 1.3.4.2 and 1.3.5.2). The GP and NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and the care provided is holistic and excellent. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. Residents and families interviewed stated that they were happy with the care provided.</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>PA Low</p> | <p>The activities programme is currently provided by two trained diversional therapists holding the national Certificate in Diversional Therapy and two regular volunteers. A third diversional therapist co-ordinator recently resigned, leaving in July 2018. The residents are supported Monday to Friday from 10.00 am to 5.00 pm. The two diversional therapists rotate weekly and support the residents in the dementia unit Monday to Friday from 10.00 am to 5.00 pm. The facility supports day stay residents who are supported by the care staff and diversional therapists when on site. The driver for the facility picks them up from their home in the morning and the diversional therapist based in the rest home/hospital area drives the day stay residents back to their homes each day between 3.00 pm and 4.00 pm. There is a room set aside at the facility if a day stay resident requires a bed to rest.</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 daily and as part of the formal six-monthly care plan review.</p> <p>The facility is registered with the Eden Alternative programme and has incorporated the Eden Alternative into their philosophy and mission statement, the diversional therapists interviewed stated that only seven of the ten principles are followed. This was also confirmed by the acting general manager. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered.</p> |

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| | | <p>Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive. The residents are supported by an independent advocate from the local community who also attends the residents' meetings.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes reminiscing and craft activities. Residents' files reviewed did not show evidence of 24 hour behaviour clock plans.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment. These updates do not always occur as residents' needs change. Where progress is different from expected the service does not always respond 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; however, for unresolved problems, long term care plans did not have this information included (see criterion 1.3.5.2). Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes and stated that they were happy with the care provided.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor' and nurse practitioner, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to plastic surgery, surgical and urology teams and mental health services. 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> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what</p> |

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| <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>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 for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness (expiry 07 December 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Regular inspections are carried out to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</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 shared ensuite rooms in one wing and staff/visitor toilets. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water is moderated by tempering valves and temperatures are tested weekly. The records of these revealed that temperatures are kept within a safe range.</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>Each bedroom provides enough space for residents and staff to move around safely. The bedrooms are for single accommodation, except for one room being shared by a couple. Rooms are individualised with furnishings, photos and other personal items displayed.</p> <p>There is sufficient room throughout the facility to store mobility aids, wheel chairs and mobility scooters. Staff and residents were satisfied with the bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p> | <p>FA</p> | <p>The main facility is spread across four different wings that each have a small lounge with comfortable seats and books available for quiet time. Residents are served meals in three different dining areas.</p> |

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| <p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>Most use the large dining room which has a smaller dining area set up adjacent to it and there is a separate dining room in the new wing. All are within easy walking distance from bedrooms. A choice of good sized lounges are available for activities.</p> <p>The dementia unit provides a large open lounge, separated by a semi wall with designated dining area.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>PA Moderate</p> | <p>Laundry is washed and dried on site in a designated laundry by dedicated laundry staff who are employed seven days a week. The laundry staff interviewed demonstrated a good knowledge about safe and hygienic processes, using 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.</p> <p>A team of cleaners receive ongoing support and training from a household manger and have completed an NZQA Level 2 qualification in cleaning. This was confirmed in interview with cleaning staff and review of training records. When not in use, cleaning chemicals were stored in a lockable cupboard and were in appropriately labelled containers. There is an improvement required in the secure unit (Fern Haven) where a cleaning trolley was observed to be left unattended.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the visiting chemical supplier weekly.</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>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.</p> <p>A fully equipped civil defence kit is easily accessible on site and its contents checked regularly. There is sufficient food and water available for a maximum of 81 residents for five days in the event of a civil defence emergency. An onsite generator is available for use during power outages. This and the emergency lighting is checked for functionality monthly. Gas ovens and barbeques are available for cooking if there is no electricity. Surplus blankets are stored for warmth.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 22 February this year. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells and this was observed.</p> |

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| | | Appropriate security arrangements are in place. There are security stays on all windows, doors are locked at a predetermined time and a security company patrols the premises at night. |
| <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 | All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by electricity in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. |
| <p>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 pharmacist, GP, NP and population health. The infection control programme and manual are reviewed annually.</p> <p>The clinical nurse administrator/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 general manager, all staff, and tabled at the quality/risk committee meeting. This committee includes the general manager, IPC coordinator, clinical nurse leader, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for seven years. She has undertaken regular training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |

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| <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> | <p>FA</p> | <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 2018 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | <p>FA</p> | <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 when the facility had gastroenteritis outbreaks in September 2017 and May 2018.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <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. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plans 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. Trends are identified from the past year and this is reported by the IPC and</p> |

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| | | <p>reported to the staff. In May of 2018, 56 residents and 21 staff consented to the flu vaccine. Nine residents consented to the shingles vaccine and 12 residents also consented to the pneumovac vaccine.</p> <p>The facility has had a total of 116 infections since February 2018. The residents' files reviewed did not always highlight short term care plans and long-term care plans did not evidence residents who frequently had infections and interventions to reduce and minimise the risk of infections (please see criterion 1.3.5.2). Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally within the group.</p> <p>A summary report for two recent gastrointestinal infection outbreaks in September 2017 where 52 residents and 38 staff were effected, and in May 2018 where 10 residents and eight staff were effected, was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the events have now been incorporated into practice, with additional staff education implemented. The ten residents effected were not included in the May 2018 monthly surveillance results.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The full time employed physiotherapist is the restraint coordinator. This person provides support and oversight for enabler and restraint use and demonstrated a good understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, eight residents were using lap belts and bed rails as restraints and seven residents were using the same voluntarily at their request as enablers. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p> | <p>PA Low</p> | <p>The restraint approval group, which comprises the physiotherapist/coordinator, both clinical leaders, a diversional therapist and either the GP or nurse practitioner, are responsible for approving use of restraints and the overall restraint process. The group meet at least every six months. Review of restraint approval group meeting minutes, and interviews with the coordinator confirmed clear lines of accountability, that all restraints had been approved, and that the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was seen in the consent and assessment forms for each restraint. The use of a restraint or an enabler is not reliably documented in</p> |

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| restraint use and this process is made known to service providers and others. | | each plan of care. |
| Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the standard. The restraint coordinator who is a registered physiotherapist undertakes the initial assessment with sign off by an RN, and input from the resident's family/whānau/EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner or the nurse practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint. |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | <p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>The restraint register is maintained and updated as required. This is reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p> |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | Review of residents' files showed that the individual use of restraints is reviewed six monthly. The previous system in use for reviewing individual use, included many of the aspects expected for an overall quality review which were not relevant to the individual. The individual evaluation/review process has now been modified to ensure it focuses on the person. Information about the restraints in use were missing from interRAI long term care plans and there is an improvement required related to this in standard 2.2.1. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. |

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| | | The evaluation covers all requirements of the standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval group undertakes a six-monthly review of all restraint use which includes all the requirements of this standard. Interview with the restraint coordinator, minutes of these meetings and the results of internal audits confirmed that monitoring and quality review of overall restraint use is occurring. The review considers the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and any feedback from the GP/nurse practitioner, staff and families. Any changes to policies, guidelines, education and processes are implemented if indicated. |

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) |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | <p>Staff training is planned annually and includes mandatory subjects such as infection control, emergency management and consumer rights. Individual attendance at education and those requiring ongoing competency is monitored by the training coordinator who follows up on staff where necessary.</p> <p>Staff interviewed said changes in some key staffing positions (kitchen/DT/management) had interfered with the timing of completing performance appraisals.</p> | Six of the ten staff files sampled showed that performance appraisals were overdue. | <p>Provide evidence that all staff engage in regular performance appraisals.</p> <p>60 days</p> |
| <p>Criterion 1.2.8.1</p> <p>There is a clearly documented and</p> | PA Moderate | Residents in the common area in the secure unit were observed as unattended for at least four minutes, while two staff were attending to one resident and the other was occupied elsewhere. | Residents were left unattended in | Ensure there is at least one staff member |

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| implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | | | <p>the common area in the secure unit for at least four minutes.</p> <p>No care staff were on the floor in the hospital /rest home wings for 20 minutes during afternoon handover.</p> | <p>with residents at all times in the dementia unit.</p> <p>Rearrange staff hours of duty to ensure cover in the hospital/rest home area during shift hand over times.</p> <p>30 days</p> |
| <p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p> | PA Moderate | <p>Food procurement, production and preparation comply with current legislation and guidelines. The cook interviewed was aware of the guidelines. Not all food in the fridge and chiller of the main kitchen or the kitchenette in the dementia unit had food covered or dated or appropriately placed. On the day of audit, the fridge in the main kitchen was observed to have 'fortisip' made with the 13 August 2018 date. The chiller had cooked and raw meat placed on higher shelves above other food. The chiller also had defrosted chicken pieces in an open bag that was not labelled or dated and was sitting in a tray on the floor of the chiller in a pool of its liquid. The kitchenette fridge in the dementia unit had an opened tin of condensed milk with no opened date, the remaining contents in the tin appeared to of expired. There was a container with fruit salad also in the fridge that was not labelled and/or dated. There was food in the dry stores that had been repacked in new containers; these containers were labelled but did not have dates on them (eg, bread crumbs, golden syrup).</p> | <p>Not all food in the fridges, chiller and dry stores are stored appropriately or have expiry dates documented.</p> | <p>Provide evidence that that storage of food complies with current legislation and guidelines.</p> <p>7 days</p> |
| <p>Criterion 1.3.3.1</p> <p>Each stage of service provision</p> | PA Low | <p>The physiotherapist has been formally trained to complete interRAI assessments. The physiotherapist interviewed stated that when completing residents' long-term care plans they gather information from the residents' interRAI assessments, from</p> | <p>There is no documented evidence that</p> | <p>Provide evidence that a registered</p> |

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| <p>(assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p> | | <p>progress notes and discussions with other staff. The clinical nurse administrator and clinical nurse leader interviewed confirmed that any care plans developed by the physiotherapist are discussed with her. There was no documented evidenced at the time of audit that this discussion occurs and the care plans are supported and signed off by a registered nurse.</p> | <p>the long-term care plans created by the physiotherapist are signed off by a registered nurse.</p> | <p>nurse agrees to and signs of all resident care plans as per contractual requirements.</p> <p>90 days</p> |
| <p>Criterion 1.3.4.2 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> | <p>PA Moderate</p> | <p>The residents are seen by the GP or NP regularly and as their needs change, evidence of changes for the resident were sighted in the resident's progress notes and regular physiotherapy assessments and updates. Information to support residents who are at high risk of falling were seen in the resident's long-term care plans, mobility and transfer plans and daily activity summaries in each of the resident's rooms. 'High falls' signs are also sighted on residents' doors. The residents and families interviewed stated that they were happy with the communication and care provided. Six of 15 residents' files reviewed (three residents from the dementia unit, two from the hospital and one resident from the rest home), had a total of 27 unwitnessed falls between January 2018 and the day of audit. An incident form is completed, an assessment is completed by a registered nurse which includes the taking of basic vital observations and a physical assessment to check for injury; however, neurological observations are not completed. One resident had nine unwitnessed falls between April 2018 to August 2018, one resident had four unwitnessed falls between February 2018 to June 2018, one resident had two unwitnessed falls between February 2018 and June 2018. One resident had one syncope and three unwitnessed falls, two of those three falls resulted in the resident sustaining two separate fractures, requiring a transfer to an acute hospital setting. One resident had five unwitnessed falls between May 2018 and August 2018, one resident had four unwitnessed falls between January 2018 and June 2018.</p> <p>The clinical nurse administrator, clinical nurse leader and NP interviewed stated that they are aware of the changes and increased level of care and interventions</p> | <p>There is insufficient evidence that neurological observations are being completed for residents with unwitnessed falls. Re-assessments of residents who are showing signs of change is not occurring within a reasonable timeframe.</p> | <p>To ensure that assessments of residents occurs according to best safe practice and contractual requirements.</p> <p>30 days</p> |

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| | | <p>required by staff to support residents. Staff interviewed confirmed the level of care required to support the residents with mobility and daily activities of living and that this was also discussed at handover. Evidence of the needs required by the residents and changes were sighted in the resident's progress, physiotherapy GP and NP notes, but there is no evidence of discussions occurring re residents requiring a change in level of care due to a deterioration in the resident's wellbeing.</p> <p>One resident admitted to the dementia unit in June of 2016 has had a deteriorated in health. Progress and physiotherapy notes identify that the resident had a fall at the beginning of July and since then the resident remains non-weight bearing and has required two staff for all mobility and daily activities of living. The resident requires a hoist for all transfers and support with regular repositioning and turning overnight. The resident is also requiring the regular intervention of a tens machine for pain. The resident is regularly seen by the GP and NP. Family were not available to be interviewed at the time of audit.</p> <p>One resident was admitted to the facility in July of 2014 and now resides in the dementia unit. Progress and physiotherapy notes identify that the resident at the beginning of June 2018 was requiring one staff member to assist getting in and out of bed, to walk, stand and required support with eating. In the afternoons, the resident requires the support of two staff to walk and required support with regular repositioning and turning overnight. At the time of audit, the resident was not walking and required the support of two staff for all mobility and daily activities of living. The resident is regularly seen by the GP and NP. Communication sighted in the resident's notes evidenced that the family are happy with the care and have expressed that they want their family member to remain in the dementia unit.</p> <p>One resident admitted to the rest home in April of 2018 has deteriorated in health. Progress and physiotherapy notes identify that the resident was independent with transfers at time of admission but in June of 2018 is now requiring two staff to transfer and in July of 2018 now requires a standing hoist for all transfers and mobility and the support of two staff for all daily activities of living. The resident has been seen regularly by the GP and NP for two unresolved infections, nine falls since admission and being nocturnal. The resident now requires the support of a restraint. Communication sighted in the resident's notes evidenced the family are notified of all changes and events and are happy with the care provided.</p> | | |
| Criterion 1.3.5.2 | PA | All residents have been seen by the GP and/or NP as needs or changes have | Three of 15 | Provide |

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| <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>Moderate</p> | <p>occurred. Information about the changes in care for residents is discussed at staff handover, noted on the handover sheets and sighted on the whiteboard in the treatment rooms. Residents and families interviewed were happy with the care and communication provided by staff. Five of 15 residents' files reviewed identified that one resident had five infections from January 2018 to July 2018, one resident had two infections from May 2018 to July 2018, and one resident had two infections from June 2018 to July 2018. One resident had six infections from February 2018 to July 2018. One resident had two unresolved infections that required three courses of antibiotics each time between April 2018 and July 2018. The short-term care plans had all been evaluated and closed. The information had not been transferred to a long-term care plan to acknowledge the multiple episodes of infections and to reduce and minimise the risk of ongoing infections.</p> <p>Four of 15 residents' files reviewed showed evidence of information about the residents required care throughout the progress notes and/or physiotherapy assessment. This information was not always supported in a short and/or long-term care plan as the need required. One resident requires an eye patch and daily wound care to the effected eye and did not have an initial short term, long term care plan or a wound management plan. One resident discharged from an acute setting following a fall at the facility on the 21 June 2018 did not have an initial short term or long-term care plan to support the resident's unstable fractures, pain and mobility and rehabilitation that is currently required and is ongoing. One resident requiring prophylactic antibiotics for an ongoing infection had this information identified in the interRAI, but this was not sighted in a long-term care plan. One resident requiring antibiotics in August 2018 in the dementia unit for an infection does not have a short-term care plan. The clinical nurse leader, clinical nurse administrator and staff interviewed stated that they were aware of the requirements for the residents, residents were discussed at handover but acknowledged the required information was not documented. Residents and families interviewed stated that they were happy with the care provided.</p> | <p>residents' files reviewed did not have initial short-term care plans developed in every acute situation, and not all information in the short-term care plans for the remaining six residents' files reviewed is then transferred to long term care plans.</p> | <p>evidence that residents' interim and changing needs are documented in short and long-term care plans as per contractual requirements.</p> <p>90 days</p> |
| <p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths</p> | <p>PA Low</p> | <p>The five residents' files reviewed had challenging behaviours that identified the behaviour, intervention and outcome in the progress notes. Long term care plans also identified the challenging behaviours of the resident. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process and care provided. The five residents admitted (one in July 2006, one in April 2013, one in July 2014 and two in June 2016), did not evidence a 24-hour</p> | <p>Five of five residents' files reviewed in the dementia unit did not have a 24-hour behaviour</p> | <p>Ensure that all residents in the dementia unit have a 24-hour challenging</p> |

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| (skills, resources, and interests) that are meaningful to the consumer. | | behaviour clock to support challenging behaviours for the resident over a 24-hour period. | clock plan to support challenging behaviour. | behaviour plan to meet contractual requirements. 30 days |
| Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals. | PA Moderate | Inspection of all areas throughout the audit revealed that cleaning staff stay close to their cleaning trolleys and put these away when not in use. The chemical supply room in the main building is secured by keypad entry as is the cleaning room in the dementia unit. Care was taken to pack away vacuum cleaners when unattended. During interview staff said they had been instructed to not take their trolleys into bedrooms. The cleaning trolley with chemicals on top was left in a corridor of the dementia unit for several minutes and no staff were in the area. | The cleaning trolley with chemicals was left unobserved and within easy reach of the residents in the secure unit. | Ensure all steps are taken to prevent confused residents from accessing cleaning chemicals. 7 days |
| Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. | PA Low | Details about manual handling, mobilisation and use of restraint or enablers are provided in the 'wardrobe plans' in each resident's bedroom. This is not reliably included in the interRAI long term care plans (in 8 of 15 files reviewed) which poses a risk that the nurse practitioner and GP are not seeing a full picture of the resident during interRAI reviews. | Information about restraint interventions has not been included in eight of the residents' interRAI care plans. | Provide evidence that all restraint use is documented in interRAI long term care plans. 90 days |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.