Claud Switzer Memorial Trust Board - Switzer Residential Care

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Claud Switzer Memorial Trust Board
Premises audited:	Switzer Residential Care
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: 20 November 2019 End date: 21 November 2019

Proposed changes to current services (if any): Reconfiguration to convert a single room to a (dual purpose) double room to be used by a couple, which increases the number of dual service beds from 21 to 22.

Total beds occupied across all premises included in the audit on the first day of the audit: 92

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

Claud Switzer provides rest home, hospital and dementia levels of care for up to 92 residents and there were 92 residents during this unannounced surveillance audit. This is an increase in one resident room from a single room to a double room which was assessed a suitable for either rest home or hospital level of care.

This audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The service continues to implement a quality and risk management system which is embedded into practice.

There is one area of continuous improvement around reducing the number of residents' falls.

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.

Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including when a resident is involved in an incident or has a change in their current health. There is an established system implemented for the management of complaints. There are very few complaints received.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. A general manager/registered nurse (RN) is responsible for day-to-day operations. She is supported by a facility manager and a nurse manager/registered nurse. Goals are documented for the service with evidence of regular reviews.

A quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff includes in-service education, impromptu talks and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

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.

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files included medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered and enrolled nurses are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activity team implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the meals. Snacks are available at all times.

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.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule being implemented.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. During the audit there were 13 residents using restraints and 10 residents using bedrails as enablers. Staff receive regular education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There has been one outbreak of influenza A.

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	16	0	0	0	0	0
Criteria	1	40	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy describes the management of the complaints process. Complaints forms are available and located in a visible location at reception adjacent to a complaints/suggestion box. Information about complaints is provided on admission. Interviews with residents and family confirmed their understanding of the complaints process. Staff interviewed (four healthcare assistants (HCAs), five registered nurses (RNs), two enrolled nurses (ENs), one kitchen supervisor, one diversional therapist, one activities assistant, one educator) confirmed their understanding of the process around reporting complaints. There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Four complaints have been lodged in 2019 (year to date) and four were lodged in 2018. Timeframes for responding to each complaint, determined by the Health and Disability Commission (HDC) were met. Corrective actions were implemented where indicated. All complaints for 2019 were reviewed and were documented as resolved. Complainants are provided with written information on how to access advocacy services through the HDC Advocacy Service.
Standard 1.1.9:	FA	Four residents interviewed (two rest home, two hospital) stated they were welcomed on entry and were given time

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		and explanation about the services and procedures. Language and communication needs and the use of alternative information and communication methods are available and used where applicable. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen accident/incident forms reviewed for October 2019 identified family are kept informed. Three families interviewed (dementia level) confirmed they are notified of any changes in their family member's health status. Interpreter services are available if needed. Staff and family are utilised in the first instance.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Switzer Residential Care provides care for up to 92 residents across three service levels (rest home, hospital and dementia care). One room has been assessed as suitable as a double room, for either rest home or hospital level care and is currently being used by a married couple (both rest home level). This raises the number of dual-purpose beds to 22. During this surveillance audit the facility was at capacity with 34 rest home level, 43 hospital level and 15 dementia level residents. Two residents were under the young person with a disability contract (YPD) (one rest home, one hospital), two residents were under the long-term service – chronic health condition contract (LTS-CHC (both dementia level), and one resident was on respite (rest home level). The remaining residents were under the aged residential care contract (ARCC). Switzer Residential Care is a charitable trust with a board of trustees. The general manager meets monthly with the board. There is a strategic plan (2019 – 2039) that includes long-term goals, a vision, mission statement and philosophy. There is an annual business, quality improvement and risk management plan (May 2019) that details all aspects of the quality programme. Business goals are regularly reviewed with the board. Benchmarking is undertaken as part of the far North Quality & Benchmarking Group. This group meets three-monthly. "First do no harm" benchmarking is also being implemented through the Northland DHB addressing pressure injuries and falls. The service has been managed by an experienced RN who has been the general manager at Switzer Residential Care for 19 years. She will be retiring soon. Her replacement is an experienced general manager/RN who has only recently relocated to the Northland region from Christchurch. She has ten years of management experience in the aged care industry and holds master's degree in business. The DHB has been notified of this change in management via a Section 31 report. The general manager is supported by a nurse manager and a facility manager. The nurse manager has been with Switzer Residential Care for 10 years and has been in her current role for the past 18 months. The facility manager has been in his role for four years and is responsible for health and safety and maintenance. The managers have maintained at least eight hours annually of professional development activities each related to managing an aged care facility.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported via the health and safety meetings. Communication to staff is via designated team communicators. The board is provided with details relating to quality and risk performance. Discussions with the managers and staff reflected their involvement in quality and risk management processes. Young people with disabilities have input into quality improvements to the service. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. Quality and risk data, including trends in data and benchmarked results through the Far North Quality and Benchmarking Group, are discussed in the quality, board and applicable staff meetings. The facility is an Eden Alternative facility with seven of ten principles achieved. One principle is in process and two are yet to be completed. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established, implemented and are signed off when completed. Quality initiatives implemented in 2019 address (but are not limited to) catering services, human resource records, the garden area and resident cares for pressure injury management. Targeted work is also underway in 2019 to enhance staff orientation and prevent skin tears. Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety team that consists of the facility manager (health and safety officer with training through level four) and 12 elected staff. The health and safety team meet monthly. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. Hazard registers are posted throughout the facility. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. Strategies to reduce the number of resident falls remain in place since the previous audit. A rating of continuous improvement remains. The falls prevention programme is being led by the health and safety team. Strategies cover the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats, physiotherapy input, and strategies to enhance staff awareness of those residents who are at risk of falling. Toileting plans and intentional rounding are further examples of strategies being implemented.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed electronically for each incident/accident with immediate action noted and any follow up action(s) required. Fifteen accident/incident forms were reviewed for November 2019 (three challenging behaviours, two skin tears, ten falls). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are conducted for unwitnessed falls and any suspected injury to the head. Data collected on incident and accident forms is linked to the quality management system. The mangers are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided for 2019 (eg, RN shortfall, pressure injury, change in management, resident challenging behaviours that pose risk to other residents).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies cover recruitment, selection, orientation and staff training and development. Six staff files reviewed (three RNs, three healthcare assistants (HCAs) included evidence of a signed employment contract, job description relevant to the role the staff member is in, police vetting, orientation, and reference checks. All files reviewed included annual performance appraisals for those staff who have been employed for over one year. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position and continues to undergo improvements. A register is maintained of practising certificates for RNs, ENs and other health professionals. There is an implemented annual education plan. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional registration. Forty-four staff have attended external training in 2019. Six nurses out of 19 (16 RNs, 3 ENS) have completed interRAI training. There are implemented competencies for nurses related to specialised procedures and/or treatment including medication competencies and syringe driver competencies. In-service training is regularly attended by staff and is completed by a mandatory five-hour annual training programme that covers a range of topics (eg, skin tears, challenging behaviours, infection control, chemical safety, emergency training, CPR, manual handling). Self-directed learning packages compliment in-service training. Topics include (but are not limited to) challenging behaviours, code of rights, restraint minimisation, sexuality/privacy/dignity, abuse neglect, cultural safety, waste management/chemical training. There is a minimum of one staff available 24/7 with a current CPR/first aid certificate. Thirteen of seventeen healthcare assistants who work in the dementia unit have completed their dementia

		qualification. Four are recently employed and have enrolled. All staff working at the facility are encouraged to complete a dementia qualification.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. The general manager and nurse manager are both RNs with current practising certificates that work Monday through Friday. There are five wings. A minimum of one staff RN is available seven days a week, 24 hours a day. Two enrolled nurses (ENs) support RN staff, but there is always at least one RN available at all times. Registered nursing staffing across the five wings includes the AM shift with four RNs/ENs on the AM shift Monday – Friday and three long, one short shift over the weekend. The PM is staffed with one RN from 1300 – 2100 and one RN 1515 to 2300. And the night shift is staffed with one RN. An RN educator works 32 hours a week on weekdays. Additional RNs are rostered to complete interRAI assessments, admissions and discharges. HCA staffing is as follows: Kowhai wing (22 hospital, 2 rest home residents): AM: two long and three short shift HCAs; PM: two long and two short shift HCAs; night shift one HCA; Matai wing (10 rest home and 7 hospital residents): AM: two long shift HCAs; PM: one long and one short shift HCA; night one HCA; Pururi wing (dementia with 15 residents): AM: one long and one short shift HCA; PM: one long and one short shift HCA; night shift: one HCA; Kauri wing (20 rest home residents): AM one long and one short shift HCA; PM: one long shift HCA; Millie wing (14 hospital and 2 rest home): AM: one long and two short shift HCAs; PM: one long and one short shift HCAs and night one HCA; In addition, two long shift HCAs are rostered to cover where needed and the PM shift is staffed with two short shift HCAs to cover where needed. Staff, residents and relatives interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time. Residents reported that call bells are answered promptly.
Standard 1.3.12: Medicine Management	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering on the day of audit. Consent forms had been signed and the residents deemed competent to self-administer. The inhalers were in a drawer. There are no

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		standing orders. There are no vaccines stored on site. The facility uses an electronic and medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and enrolled nurses (EN) administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication room and medication fridge temperatures are checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service has a kitchen team leader and two cooks who cover the week between them. There are four kitchenhands on a rotating roster. All cooks have current food safety certificates. The kitchen team leader oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served from a bain marie in the kitchen or from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The kitchen has seafood days for Māori residents. The four weekly menu cycle is approved by a dietitian. All resident/families interviewed were satisfied with the meals. Snacks are available at all times. The food control plan was verified on 31 June 2019.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and

desired outcomes.		wound care supplies. There are currently sixteen wounds being treated. Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently three stage one facility-acquired pressure injuries. Pressure injury equipment is available. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one DT and one activities assistant who both work thirty-two hours a week. The activities assistant is currently completing the DT course. Both work across all areas. There are also volunteers who assist. On the day of audit residents were observed playing cards and scrabble, enjoying a visit from a pre-school and playing bingo. There is a weekly programme in large print on noticeboards in all areas. Every Monday each residents in the home and hospital are given a copy of the weekly programme to keep in their room. In the dementia unit staff receive a copy. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. Residents are encouraged to participate in daily chores such as folding linen and setting tables (Eden Alternative). The dementia unit residents may attend activities in the home and hospital if appropriate. HCAs in the dementia unit also participate in holding activities for the residents and there is a large cupboard of activity equipment. The DT assesses the dementia programme daily as it is dependent on residents' mood and wellbeing. There is a lot of one-on-one especially in the afternoon when 'sundowning' occurs. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a weekly church service on a Sunday and Catholic communion every Friday. Each area has a van outing weekly. There are entertainers that visit twice weekly. Special events like the Melbourne Cup, birthdays, Christmas, Matariki and Anzac Day are celebrated. The facility recently held a multi-cultural day. Māori residents enjoy special seafood days. Happy hour is every Friday, and this is followed by fish and chips. The facility has seven cats and two fish. Residents are encouraged to care for these (Eden alternative). There is weekly pet therapy and volunteers bring in dogs. There are strong links with the community. Local preschools and schools visit. One pre-school brings in babies. Residents go out to the RSA, church services and senior expo. One resident assists a relative in delivering meals on wheels. Residents have an activity assessment completed over the first few weeks following admission that describes the

		residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. There was one held on the second day of audit. Residents and relatives interviewed spoke positively about the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Except for the new admission all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short- term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry 30 June 2020). The environment and building are well-maintained. The testing and tagging of equipment and calibration of medical equipment occurs annually and records were maintained. Hot water at the tap is maintained at a safe temperature, with regular monitoring occurring. Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Outdoor pathways, seating and grounds are well-maintained. Appropriately secured handrails were provided in the toilet/shower areas, and other equipment/accessories were available to promote resident independence. In the dementia unit, the lounge area is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access. Interviews with staff confirmed there was adequate equipment. One room in a dual-purpose wing (Millie wing) has been assessed as suitable for couples at either rest home or hospital level of care. The general manager stated the intent is to use this room for couples only. Call bells are available for each bed. A privacy curtain is available for those couples who request it.
Standard 3.5:	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in

Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		the facility. Infection control data including trends is discussed at quality and staff meetings. Meeting minutes are available to staff. The facility benchmarks with the Far North quality and benchmarking group. The facility had an influenza A outbreak in July/August. This was well documented and reported to the DHB.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were 13 residents (hospital level) with restraint (eg, bedrails and chair briefs) and 10 hospital level residents who had requested bedrails as enablers. All required paperwork for the use of enablers was sighted in the two residents' files reviewed. Staff training is provided annually around restraint minimisation and managing of challenging behaviours. Staff interviews confirmed their understanding of the difference between an enabler and a restraint.

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
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The facility belongs to the Far North Quality Benchmarking Group where data is tracked, trended and compared to other aged care facilities in the Far North. Falls have reduced significantly resulting in a rating of continuous improvement.	Clinical indicator data is reviewed monthly by the health and safety team. Trends in data for this year reflect 259 falls (year to date) compared to the previous year of 335 falls (year to date). Strategies implemented to reduce the number of falls and reducing the number of injuries from falls include low beds, sensor mats, hip protectors, intentional rounding, regular toileting and enhancements to the nursing call system. The root cause of falls continues to be when residents are clinically unwell, at the end of their lives or if suffering from cognitive impairment. This previous rating of continuous improvement remains.

End of the report.