

Terrace View Lifecare Limited - Terrace View 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:

Legal entity:	Terrace View Lifecare Limited
Premises audited:	Terrace View Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 September 2020 End date: 3 September 2020
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:	41

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Terrace View Retirement Village can provide rest home and hospital level care for up to 63 residents. The facility contract allows for beds to be used flexibly, which provides a mix of rest home and hospital beds. In addition apartment or care suites are available for privately paying residents or can be used as flexi beds. The service is operated by Ennor Investments Limited and managed by a facility manager and a clinical nurse manager, who have both been in their positions for approximately four years. Residents and families spoke positively about the care provided.

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

This audit has resulted in one area of continuous improvement being identified, relating to the reduction of staff workplace injuries, particularly around falls prevention. Two areas requiring improvement are raised in relation in staff training records, and staffing levels in response to resident acuity.

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.

Residents and their families/whānau are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these were observed to be respected. Services are provided in a way that supports personal privacy, independence, individuality and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and family/whānau is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and family/whānau with appropriate information required 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 and compliments system is in place and a complaint register is maintained and demonstrated that complaints were resolved promptly and effectively. Complaints are considered as an opportunity for quality improvement.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

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

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

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

Continuum of service delivery

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

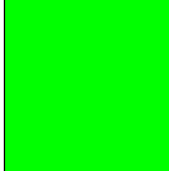
Residents' needs are assessed on admission by a multidisciplinary team, including a registered nurse and general practitioner. Care plans are individualised, based on a comprehensive range of information, and accommodate any problems that arise. Files reviewed demonstrated that the care provided and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

The planned activity programme provides residents with a variety of meaningful activities for both individuals and groups while maintaining links with the community.

Medicines are safely managed and administered by competently trained staff.

The food service meets the nutritional needs of the residents with special requirements catered for. Food is safely managed, and residents expressed satisfaction with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The Terrace View Retirement Village is a modern purpose-built facility, with integrated services and utilities which meet the needs of residents. The facility was clean and well maintained, and there was a current building warrant of fitness on display. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature, and there are a number of accessible external areas.

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.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. A fire evacuation plan is in place, and procedures are regularly practised. A centralised call bell system is in place, and residents reported timely staff response times. Security is maintained through the use of an electronic access control system.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs, and was clearly documented. Staff have received training on restraint minimisation and enabler use and demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by a trained infection control coordinator, aims to prevent, control/contain, and manage infections. The programme is reviewed annually. Specialist infection and control advice is accessed as required.

Terrace View Retirement Village followed Ministry of Health guidelines for alert levels throughout the restrictions for Covid-19. These guidelines were printed for staff in all departments and staff were expected to sign that they understood them. A norovirus outbreak that occurred in June 2020 was handled in a manner that kept infection to a minimum. Extra staff education was undertaken, and measures put in place to limit both staff and resident exposure. Correct procedures were followed, with logs kept and the community and public health team notified appropriately.

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 implemented when needed.

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	43	0	2	0	0	0
Criteria	1	90	0	2	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Terrace View Retirement Village (Terrace View) 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 then biannually (last completed 15 July 2019) as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Seven 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 are defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<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 clinical manager provided an example of a resident requiring an advocate regarding family issues. In this instance the facility manager filled the role of advocate.</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. Residents are assisted to be ready for any transport picking them up to attend community groups that they are a part of, such as Rotary.</p> <p>The facility normally 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. During Covid-19 restrictions video chats and phone calls were utilised to connect residents to friends and family outside the facility. Family interviewed stated that they appreciated the efforts taken by staff during this time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint. Staff interviewed were able to state what they would do if a resident or family member wished to make a complaint. Complaints forms were available at reception. The facility manager stated that residents and family members often call in to her office for discussions and if there were issues these would be raised.</p> <p>There is an electronic complaint register in place, which provides details of complaints made. The complaint register recorded that there were five complaints made in 2019, and two complaints are recorded so far for 2020. The register recorded who is managing the complaint, and the status of the complaint. Complaints reviewed showed that complaints were managed in a timely manner in line with their policies and the funders expectations. Action plans showed any required follow up and improvements have been made where possible. One Health and Disability Commissioner's complaint has been received in the past year. Detailed documentation was viewed of the process, timeline and actions taken regarding this complaint. The organisation provided all required documentation to the commissioner's office, and the complaint has now been closed.</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/families/whānau interviewed were aware of the Code and had received opportunities to discuss it with staff. They received a copy of the Code, and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission pack, provided prior to admission. The Code was displayed inside the main entrance and brochures were available at reception, together with information on the Advocacy Service, and complaint/compliment forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents/families/whānau confirmed that they received services in a manner that has regard for their personal privacy, dignity and respect. Staff were observed offering choices and encouraging independence in activities of daily living. All residents have a private room/suite that are designed to cater for their needs from admission through all levels of care. Care plans included documentation relating to the residents' abilities and strategies to maximise independence. Residents can continue with community activities, such as Bridge Club, independently.</p> <p>Seven files reviewed demonstrated evidence of information on each resident's individual cultural, religious, and social needs. These were incorporated into their care plans.</p> <p>Staff understood the service's policy on abuse and neglect and were familiar with the process if signs were observed. Education sessions are held on abuse and neglect on a biannual cycle (18 April 2019). Families/whānau interviewed had never witnessed any form of abuse, neglect, or discrimination.</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 are able to 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. There is a current Māori health plan developed with input from cultural advisers. On the day of audit there were no residents or staff that identified as Māori. Training on cultural safety and the Treaty of Waitangi is part of staff orientation and on a biannual cycle (last completed 11 April 2019).</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,</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed (eg, those that wished to attend church services). The resident satisfaction survey confirmed that individual needs are being met.</p>

and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, wound care specialist, dietitian, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Registered nurses are encouraged to complete post graduate study, while care staff are supported to complete level four New Zealand Qualification Authority (NZQA) training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although this has not been required due to all residents being able to speak English and the use of family members and communication cards for those with communication difficulties.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>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 the monthly reports to the directors were viewed. These reports were comprehensive and showed adequate information to monitor performance, which included financial performance, emerging risks and issues. The reports</p>

		<p>included information from previous months so that trends can be identified.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for four years. Responsibilities and accountabilities were defined in a job description and individual employment agreement. The facility manager confirmed knowledge and experience of the sector, including the regulatory and reporting requirements.</p> <p>The service holds contracts with Canterbury DHB for aged care, YPD, respite care, complex medical conditions, and palliative care. The facility manager stated all beds (63) can be used for DHB contracted patients/residents. There are private paying residents some of whom have Occupational Rights Agreements (ORA). At the time of audit 41 residents, with 26 under hospital level care (two with an ORA agreement) and 15 under the rest home contract. No one was receiving palliative care or respite care.</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>	FA	<p>When the facility manager is absent, the clinical nurse manager takes over the responsibility for the day to day management of the facility. When the clinical nurse manager is absent, one of the experienced registered nurses performs the clinical manager role and takes responsibility for any clinical issues that may arise. When the maintenance manager is absent the preferred contractors are engaged to directly address any issues that arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation uses the policies and templates developed by an external quality contractor for its planned quality and risk system. These reflected the principles of continuous quality improvement and included a quality and risk plan and an internal audit schedule. The management of incidents and complaints, as well as clinical indicators, such as falls, infections, and pressure injuries, are recorded into the system, which allows for reports to be generated and for analysis and benchmarking to be undertaken.</p> <p>The monthly management meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. Monthly management reports reviewed showed quality and risk being communicated to the directors, with sufficient data provided to allow for trend analysis. Staff reported their involvement in quality and risk management activities through discussions at staff meetings, involvement in policy review, and feedback from audits.</p> <p>The external quality contractor's web portal allows for the central collection of data. From this data specific monthly reports are generated. The reports reviewed included adverse event and infection</p>

		<p>data, which included benchmarking and trending analysis. A corrective action log is in place to address any shortfalls and is reviewed at the monthly management meeting. There have been a number of different surveys developed to gather feedback from stakeholders. In the past year residents, family, food, and staff satisfaction surveys have all been completed. Areas of action are discussed at management meetings and entered into the corrective action register. Examples of actions taken in response to survey feedback included the decision to contract out the kitchen and meals to a food services contractor and the decision to provide the main meal in the evening.</p> <p>Projects for continuous improvement are being actively undertaken. Six were sighted as part of this audit that included a review of food services, addressing interRAI completion rates, activities planning during the Covid-19 lockdown, reducing ACC costs by reducing staff slips, trips and falls, increasing health care assistant (HCA) qualifications, and the management of a norovirus outbreak. These were reviewed and demonstrated planning, action and the commencement of monitoring; however, measurement of the outcome of the improvements were not established at the start of each of these projects, which made it difficult to measure the level of improvement achieved. The project relating to reducing staff slips, trips and falls in partnership with ACC achieved a reduction in staff slips, trips and fall injuries (refer criterion 1.4.2.1).</p> <p>Policies are provided by the external quality contractor and are reviewed by staff to ensure they meet the organisation's requirements. The policies covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process.</p> <p>The document control system ensures a systematic and regular review process is in place, which included referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There are identified health and safety representatives and health and safety issues are discussed at both the management and staff meetings. The risk and hazard registers were discussed and reviewed each month by the facility manager and the management team at their monthly meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an adverse event form. A sample of adverse events forms reviewed showed these were fully completed. Adverse events were investigated and actions followed-up in a timely manner. Each month adverse event data is collated, summarised and analysed, and an adverse summary is available electronically. Adverse events are discussed at the monthly management meetings and actions assigned or followed up. Minutes of these</p>

<p>the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>meetings were sighted which showed that discussion around adverse events were a standard agenda item. The clinical nurse manager also discusses and provides feedback on adverse events at staff meetings, which again was evident from the meeting minutes that were reviewed. A summary of adverse events is also included in the facility manager's monthly report to the directors, which were sighted.</p> <p>The facility manager described 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, and records of these notification were sighted.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies were being consistently implemented and all required human resources documentation was present.</p> <p>Staff orientation was comprehensive and included training on all necessary components relevant to the role. Signed checklists were used to record each part of the orientation process, which are placed on the employee's file. The orientation process also includes the buddying of new staff for up to two weeks, depending on the new employee's experience. Staff reported that the orientation process prepared them well for their role and that they felt well supported. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including core training requirements, which are outlined in the training plan. Training is provided biennially, annually or biannually, and delivered either internally or by external contractors, depending on the topic. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two care staff were currently enrolled in this programme and were working towards qualifications. Training records viewed showed that regular training is being provided; however, records do not confirm that all staff have completed all regularly required training.</p> <p>There were sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>The roster has been in place for four years with some minor adjustments to assist with staffing. There is a documented policy and tools for individual assessment of acuity level. The manager and clinical nurse manager meet regularly to discuss staff as part of their managers' meeting; however, the acuity information is not used to inform this meeting. The review of occupancy data over the past year showed a shift in resident acuity, with an increase in hospital level beds and a decrease in rest home beds.</p> <p>Residents and family interviewed felt the care staff were available and responded to their needs in a timely manner. Call bell monitoring data reviewed showed that calls bells were responded to, the majority of the time, in a timely manner with occasions when a person might wait around ten minutes. This is regularly monitored by the manager.</p> <p>Observations and review of the roster over a four-month period, and interview with the clinical nurse manager showed that it can be difficult to provide adequate replacement staff to cover any unplanned absence. This resulted in existing staff working additional hours, the clinical nurse manager working to provide cover, or the shift being left unfilled, on some occasions.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Seven files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance</p>

		<p>with contractual requirements. Service charges comply with contractual requirements.</p> <p>Admissions are encouraged between the hours of 8 am to 3 pm to ensure medications can be obtained from the pharmacy.</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 appropriate processes were followed. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the days of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. The medication round observed was handled in a safe and appropriate manner.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. On arrival, the night staff check the medication against the prescription and enter it into Medi-map. 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 included 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</p>

		<p>charts.</p> <p>There were eight residents who self-administer medications at the time of audit. Education had been provided and an assessment completed by the RN and signed by the GP. Staff check on medication rounds and document as the dose is supplied. The process is reviewed three monthly by the GP.</p> <p>There was an implemented process for comprehensive analysis of any medication errors. Errors that had been reported were handled according to protocol.</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>FA</p>	<p>The food service is provided on site by an external company that provides both the meals and the kitchen staff. This is a new contract that commenced recently. Meals provided are in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (1 May 2020). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Ministry for Primary Industries (26 May 2020). Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, from satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Birthdays and special activity days are celebrated with cakes.</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</p>	<p>FA</p>	<p>Residents are able to enter the facility and remain through all levels of care. If it becomes unsafe for a resident to continue receiving care at Terrace View then a referral is sent to the NASC assessment team for reassessment and family are supported to find another provider in consultation with the GP.</p>

consumer and/or their family/whānau is managed by the organisation, where appropriate.		There is a clause in the admission agreement that allows for termination of a resident's placement.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, clinical information is gained using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The seven care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of four trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Seven care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The triggers identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical interventions are followed and care is of an 'excellent quality'. Care staff confirmed that care was provided as outlined in the documentation and amendments to care were informed through the handover process. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs, such as hoists and pressure relieving devices.
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	FA	The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy and an activities coordinator. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. An activity care plan is developed, and assessments are regularly reviewed to help formulate an activities programme that is meaningful to the

<p>the service.</p>		<p>residents. The residents' activity programme is evaluated through residents' meeting minutes, satisfaction surveys and as part of the formal six-monthly care plan reviews.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities, such as newspaper reading, shopping trips, card games movies and exercises. Individual, group activities and regular events are offered. Residents and families/whānau interviewed expressed that the activities were appropriate and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The care staff are required to give a verbal handover to the RN before leaving.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for urinary tract infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Five of the seven files reviewed had changes made to interventions that had been signed and dated, as was appropriate. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents remain under their GP, unless transferring from out of town. If the need for other non-urgent services are indicated or requested, the RN in consultation with the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the dietitian, NASC team, and wound specialist. A physiotherapist visits on a weekly basis and there is a book for referrals to be documented in. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The maintenance manager oversees the waste management for the site, with dedicated secure areas for the storage of waste until it is collected. The chemicals are provided from a single supplier, and these are stored</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>securely. There is a pre-set chemical dispenser which is used for decanting and diluting the chemicals in use. The supplier provides chemical handling training for service providers, and material safety data sheets were sighted and are available adjacent to the chemical dispenser. Good stocks of appropriate personal protective equipment (PPE) were available to service providers when handling chemicals, infectious materials, or undertaking cleaning tasks, 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>The Terrace View facility is a modern building that is seven years old. The physical environment is light, spacious and well maintained. It has comprehensive building systems in place to ensure the residents are safe and secure, which includes a range of backup systems to cope if utility services are lost. A current building warrant of fitness (expiry date 1st January 2021) was on public display in the reception area. Adjacent to this was the facility's LPG Compliance Certificate (expiry date 23 July 2021) for having 540kg of LPG stored on site.</p> <p>In relation to health and safety a project to reduce staff slips and falls was undertaken with a measured successful outcome. In recognition of the success of this project a continuous improvement has been awarded.</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 is routinely completed, and recorded in a register which was sighted. Electrical tags were also checked throughout the facility and found to be current.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. A maintenance book is kept at reception, where any maintenance requirements are recorded. The maintenance manager checks this book each morning and arranges for the work to be completed. Completed tasks or progress on tasks is recorded in the maintenance book. Maintenance requirements are also discussed at the weekly management meeting and recorded as a hazard if required.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>There are 63 resident rooms across all areas of the facility. Each person's room has their own ensuite, which includes wet area shower, toilet, basin, appropriate handrails, and a call system. There are a number of additional toilets throughout the facility, for resident, visitor or staff use.</p>

<p>toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>These toilets were fitted with privacy locks, approved handrails and connected to the call system.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are spacious and provided single accommodation at the time of this audit. Rooms are personalised with furnishings, photos and other personal items displayed. Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely.</p> <p>There is room to store mobility aids in bedrooms and a dedicated communal area where hoists and other equipment are stored. There is also a separate room for storing and charging mobility scooters. Staff and residents reported the adequacy of bedrooms and storage space.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>A range of communal areas are available for residents to engage in activities. These areas are spacious and enable easy access for both residents and staff. The furniture is appropriate to the setting and the residents' needs. There are two dining areas, two lounge areas, a large media room, a library, and a number of smaller lounge or sitting areas. In addition, there are some outdoor sitting areas and a walkway has been developed through the trees at the rear of the property. Residents can access areas for privacy, if required.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site. The laundry is configured to allow for the dirty to clean flow of laundry. Commercial laundry appliances are in use, which can wash at a range of temperatures, and use automated detergent dispensing. A dedicated team of care staff completes laundry at night, with the assistance of other care staff on other shifts. This person demonstrated sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a three-person designated cleaning team. Training records showed that each of these people have received training on cleaning and chemical use. Cleaning supplies, cleaning carts, and PPE was all stored in a secure room. In addition, a separate secure area is used for the decanting and mixing of chemicals, storing mops and other cleaning equipment</p> <p>Cleaning and laundry processes are monitored by checklists reviewed by the household manager and through the quality meetings and the internal audit programme.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 2 April 2020. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being undertaken on 24 July 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Fire training is also provided for residents, with the most recent being on 20 March 2020.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region. Water storage tanks are located around the complex. There is a generator on site. Emergency lighting is regularly tested.</p> <p>A call bell system is in place, to alert staff to residents requiring assistance. There are multiple call points in each resident's room and ensuite, as well as throughout the other communal areas. The call bell system produces a monthly report of call bell response times, which are reviewed by the facility manager, and discussed at the management meeting. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors are locked at predetermined times by the computerised access control system and cards readers allow for access outside of these hours, or to restricted areas. All access is controlled and recorded by the access control system and reports can be generated if required.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. There were a number of doors around the facility leading to outdoor garden areas and walkways. Heating is provided by underfloor heating and by heat pumps in communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed</p>

<p>which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>annually (last reviewed 22 May 2020).</p> <p>The registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality/risk committee meeting. This committee includes the facility manager, clinical nurse manager, IPC coordinator, 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>During Covid-19 restrictions guidelines were followed from the Ministry of Health and passed on to staff in all departments in writing.</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>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. She has attended the Infection Prevention and Control Nurses Conference (21-23 September 2019) and attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at Ashburton hospital and the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2019 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>Covid-19 restrictions on the day of audit required signing in, completing a questionnaire, having the person's temperature taken and wearing a mask for all staff and visitors.</p>

service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained and the register was sighted as up to date in this education area. 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 Covid-19 restrictions were in place. Education included hand hygiene, donning and doffing of personal protective equipment and disaster management and was required for all staff.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing.</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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and included infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated 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. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality and the IPC committee.</p> <p>A summary report for a recent gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint approval group, made up of the attending medical practitioner, registered nurse, clinical nurse manager and the activities co-ordinator, are responsible for the approval of the use of restraints and the restraint processes. The clinical nurse manager (CNM) is responsible for ensuring the restraint register is maintained accurately at all times.</p> <p>On the day of audit, there were no restraints in use, and the CNM reported there had been no</p>

		<p>restraints in use over the past four years, which was confirmed by looking at the restraint register.</p> <p>There was one enabler in place, which was for a bedrail. The bedrail had been in use for almost six months. On viewing the resident's file, it was evident that an assessment process had been completed, the person and their family were consulted, and a signed consent was in place. A review of the enabler use had been completed, and details of the enabler's use were included in the person's care plan. An enabler monitoring sheet check was in place, which was sighted, and recorded hourly checking of the bedrails throughout the night when the bedrails were in place.</p> <p>It was evident through observations and discussions with the CNM and care staff, that enablers were implemented in the least restrictive manner, and with the consent of the person and/or their family.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</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>Six individual training records and attendance records in a sample of planned training were sighted and reviewed. Training records viewed showed that regular training is being provided as planned and attendance records are maintained. On checking for attendance for individual staff for required core training, not all staff had completed each of the core training sessions. Review of the system to monitor this identified a register, however this had not been completed for the last three years. There was currently no other system in place to track which staff have, or have not, completed the required core training sessions.</p> <p>With the recent Covid-19 pandemic, the facility has provided a range of training for staff. A spreadsheet demonstrated that all but three staff completed procedure training and 20 out of 41 staff completed policy and PPE training. The spreadsheet was provided on request from the audit team following the audit. Biannual compulsory core pain management training was provided to 15 out of 26 RN and caregiver staff in March 2020.</p>	<p>The system in place to record training does not identify which service providers have not completed training or show when service providers are due for retraining, for example, attending compulsory topics biennially.</p>	<p>Implement a recording system to ensure that all staff have completed the defined training requirements</p> <p>180 days</p>

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Low</p>	<p>Interview with the Manager and Clinical Nurse Manager confirmed that meetings occur regularly and discussions occur related to staffing however it was stated that no minutes are kept of these meeting. On asking how acuity decisions are made both stated that this was through discussion. No data could be provided.</p> <p>On review of the roster records and in discussion with the clinical nurse manager there has been minor increases to the health care assistant hours, and laundry work is now undertaken at night. Additional days have been provided to RNs to complete interRAI work. The residents are spread across a large facility with care staff allocated into areas. In the morning two registered nursing staff provide clinical oversight while in the afternoon and night, one registered nurse provides oversight for the entire facility. Interviews with health care assistants reported that there were insufficient staff available to complete the work allocated to them.</p> <p>Data from occupancy based on care need levels show an increasing number of hospital level care residents and a decreasing number of rest home residents over the last 12 months, and therefore a shift in resident acuity. Additionally, both hospital and rest home residents are located in apartments and care suites both in different parts of the building.</p> <p>For 26 hospital level and 15 rest home residents there are two RNs on in the morning, one in the afternoon and one at night for the facility. Care in each individual area is provided by caregivers. The morning shift has six caregivers, with two allocated into a hospital only wing, four and a 'float' caregiver in the afternoon and one RN and one caregiver in the night with a laundry person covering bells when the care staff are busy. During weekdays the clinical nurse manager is available to assist if needed and on interview confirmed that this occurs.</p> <p>RNs interviewed reported that they have limited time to undertake oversight of clinical cares and to complete documentation for hospital level care residents. Perhaps one to two minutes a shift for most residents and more time for those who have high need.</p> <p>Caregivers interviewed also reported they are pushed every day to undertake work, that they complete laundry tasks in the morning and are involved with breakfast and morning and afternoon teas. In the afternoon</p>	<p>Policy includes use of an acuity tool to support staffing decisions. This tool is not being used for each resident to inform the clinical nurse manager and managers' meeting regarding safe staffing levels.</p>	<p>Implement the acuity tool process as defined in procedures to ensure service provider levels and skill mix safely meet the needs of residents</p> <p>180 days</p>
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		<p>they need to fold towels and flannels as they are needed for the afternoon work. It was reported they feel there is inadequate clinical supervision by the RNs.</p> <p>The RNs report they frequently work overtime (unpaid) to complete their tasks. The CNM also works additional hours.</p> <p>The roster showed that shifts are regularly (at least twice per week) short and needing replaced with another staff member working extra hours. This is also often the CNM who fills RN gaps when needed. Occasionally the shift goes unfilled.</p> <p>Adequate staffing levels were observed on the days of audit.</p> <p>Following the audit, information was provided to demonstrate an acuity process. This included:</p> <ul style="list-style-type: none"> • A sample of resident acuity assessments that are completed on admission, showing changes in health status and return from a DHB hospital • Resident acuity assessment data that shows the change in rest home and hospital residents. The required RN hours per week is then generated excluding the clinical care manager hours • Copies of meeting minutes between the facility manager and clinical care manager detailing discussion around acuity levels, staffing and rostering <p>On review of the information post audit this demonstrates adequate RN hour allocations per resident. It is not clear how the acuity data and the data in the form of totals relates, (that is where the information was sourced from), and how the allocation of hours has been calculated. No evidence was provided to evidence that the acuity assessment information was used to adjust staffing levels in response to the acuity of residents.</p> <p>As none of this information was provided while on-site the partially attained finding remains although the team accept that if this had been provided during the on-site audit it would demonstrate an acuity process is in place.</p>		
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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 1.4.2.1 All buildings, plant, and equipment comply with legislation.	CI	Click here to enter text	A project relating to reducing staff slips, trips and falls was undertaken in partnership with ACC and achieved a reduction in staff slips, trips and fall injuries, through increased awareness, good housekeeping, shared responsibility of actions, and ensuring suitable footwear is worn by staff. The success of this programme has resulted in a reduction in slips, trips and falls, with none recorded for a period of 275 days.

End of the report.