Golden Pond Private Hospital Limited - Golden Pond Private Hospital

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:	Golden Pond Private Hospital Limited
Premises audited:	Golden Pond Private Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 March 2021 End date: 9 March 2021

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: 61

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

Golden Pond Private Hospital provides rest home, hospital and palliative care for up to 61 residents. The service is operated by Golden Pond Private Hospital Limited and managed by a nurse manager and a clinical nurse. 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 records, observations and interviews with residents, family members, managers and staff and a general practitioner.

The audit has resulted in four continuous improvement ratings, related to complaints management, adverse events reporting, service delivery and emergency management. No areas were identified as requiring improvement at this audit.

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 are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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.		All standards applicable to this service fully attained with some standards exceeded.

Golden Pond Private Hospital Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Robust systems are in place for monitoring the services provided including regular daily, weekly reporting by the nurse manager to the governing body.

The facility is managed by an experienced and suitably qualified and experienced nurse manager. A quality and risk management system is in place which includes an annual schedule of internal audits activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident, family and staff satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where applicable. Meeting minutes, graphs of clinical indicators and benchmarking results are available and were reviewed. Corrective action plans are developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated, and the hazard register was current and up-to-date. A suite of policies and procedures cover the necessary areas, were current and are reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation/induction and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan, facilitate and record ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents are met. There is an on-call after-hours system in place.

Residents' information is accurately recorded, securely stored and is 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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

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

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

Safe and appropriate environment

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

The facility has been purpose built. All rooms are single with the exception of eleven studio units. Rooms are of an adequate size to provide personal cares.

Building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas in two locations are available with appropriate seating for residents.

Implemented policies and procedures guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All personal laundry is undertaken onsite with systems monitored to evaluate effectiveness. The facility was clean and tidy with cleaners on duty seven days a week.

Emergency procedures are documented and displayed. Regular six-monthly fire drills are completed and there is a sprinkler system and call points installed in case of fire. Emergency lighting is available and is checked monthly. Emergency stores are available. Residents reported a timely staff response to the nurse call system. Security is managed effectively onsite.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Five enablers and five restraints were in use at the time of audit. Restraint is only used as a last resort when all other options have been explored. Enabler use is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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.		All standards applicable to this service fully attained with some standards exceeded.

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	4	97	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Golden Pond Private Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. Staff were observed calling residents by their preferred name.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were 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.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment events in the community. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirement of Right 10 of the Code. There is also a flow chart developed and implemented to guide staff. The complaints information is provided to residents on admission and there is complaint information and forms at reception. A complaints/compliments box is also located in the reception area of the facility. The complaints register reviewed evidenced 16 complaints from January 2020 to January 2021. Seven complaints received were from the same complainant. Actions were taken through to an agreed resolution, were fully documented and completed within the required timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. All internal complaints have been closed out effectively. The date and signature of the nurse manager was evident in the complaints register reviewed. The facility has received two Health and Disability commissioner (HDC) complaints since the previous audit, both of which are still not closed out. One complaint was received in November 2019 related to clinical care and use of a hoist (the staff member involved no longer is employed at this facility) and the other complaint was received October 2020 in relation to care of a resident (the resident no longer resides at this facility). Outcomes from the 2019 complaint have already been implemented, staff received additional education and the falls prevention programme is in place and is working effectively. All staff interviewed are fully informed of their responsibilities for falls prevention and for incident management and documentation required. An assessment tool was also adopted and introduced to be used for notifying the GP or the DHB for external transfers if and when required. A continuous improvement has been awarded for the extensive action taken without waiting for the full

		outcome of the HDC complaint. The facility manager is responsible for complaints management and follow up. The facility manager has significantly improved the complaints process and provided an annual summary and comparative study of improvements from the previous year and a continuous improvement has been awarded for complaints management. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and during discussions with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families of Golden Pond Private Hospital (Golden Pond) confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and regular outings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and	FA	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.

acknowledges their individual and cultural, values and beliefs.		
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	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. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included reduction of number of urinary tract infections among residents (refer criterion 3.4.5)

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	There is a business plan for 2021 that is documented for Golden Pond Private Hospital (Golden Pond). A quality policy statement is in place. A mission statement and the organisation's philosophy is clearly documented. Quality and risk planning is clearly documented with quality and risk principals, principal values and standards of practice to be effectively met. In addition to this, the goals incorporate ongoing requirements to meet, such as the Code, standards, certification and contractual requirements, quality and risk management and continuous improvement. Service provision includes monitoring and evaluation of activities. Each objective/goal has identified strategies as to how each goal will be met, who is responsible and how they are evaluated. An organisational chart was reviewed which explains the structure of the service. The nurse manager reports weekly to the director on any concerns or issues that may have arisen. The director works two full days a week and is responsible for the accounts and the pay roll. Staff working in the weekend inform the clinical manager and/or the nurse manager of any emerging risks or issues as required. The service is managed by a nurse manager who holds relevant qualifications in healthcare and has been in this role for 24 years and has worked in the aged care sector for up to thirty years. The nurse manager is suitably skilled and experienced for the role and the responsibilities and accountabilities as defined in the job description reviewed. At interview, the nurse manager confirms comprehensive knowledge of the aged care sector, regulatory and reporting requirements and maintains currency through ongoing management and nursing education as per the training records. The nurse manger is well supported by a clinical nurse and experienced administrator. The service holds contracts with the district health board and provides hospital - medical, hospital-geriatric, rest home level care and has two designated beds for palliative care. On the day of the audit there 61 residents; 55 hospital level care, four rest home and two palliative care residents receiving care.
Standard 1.2.2: Service Management The organisation	FA	The experienced nurse manager manages the day-to-day operation of the service. When absent from the facility, the clinical nurse (who has only been in the role for two months) would continue to provide clinical input and the administrator and/or the director are able to carry out all the required duties under delegated authority. The senior

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.		registered nurses would also be available to support the clinical nurse as required.
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	Staff are made aware of the business and quality plans and those interviewed had a good understanding of the processes in place. The quality and risk system in place reflects the principles of continuous improvement. This includes the management of audit activities including regular resident/staff and family satisfaction surveys, monitoring of outcomes, clinical incidents including infection prevention and control management. The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met. Employees are to conduct themselves in a manner that avoids harm to themselves and others. The health and safety committee exists for the purpose of implementing, maintaining and monitoring a health and safety programme for residents, staff and visitors to the facility. Staff input is encouraged. The nurse manager is responsible for the health and safety programme. Hazards are identified and documented. The nurse manager described the identification, monitoring and reporting of any risks and the development of mitigation strategies. The risk register is reviewed at least annually. New risks are added to the register following a documented process. The register is current and up-to-date. There are detailed procedures to show that health and safety is managed to meet the legislative requirements. Terms of reference and care meeting minutes reviewed confirmed efficient reporting occurs, that action is taken and compared from the previous year for benchmarking purposes. Regular review and analysis occurs, and related information is reported monthly and discussed at the quality and care staff meetings. Minutes maintained were available for review. Discussion occurs on pressure injuries (if any), restraints, falls, complaints, adverse events, infections, wounds, audit results and activities programme. Staff interviewed stated they were involved in quality and risk activities through participating in the internal audits. Relative corrective action sheets are developed and implemented to a high standard and demonstrated a continuous process of quality improvement is occurring. Annual surveys, such as the staff, family and resident satisfaction surveys, are completed annually by the nurse manager. The families/residents survey indicated that residents/families were very satisfied overall with services provided. All outcomes of surveys and internal audits were compared with the previous year's outcomes and a summary was completed with any recommendations, if they required any action to be taken, by whom and were signed off when completed and dated. Any reports are displayed in the staff room. Quality improvement was

		discussed at the care staff meeting. Policies and procedures and the Frail Guidelines utilised reviewed cover all aspects of the service, service provision and contractual requirements and obligations required. All obsolete documents are managed appropriately and stored for retrieval processes if needed.
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.	CI	Staff document adverse events and near miss events on an accident/incident form. A sample of incident forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed up in a timely manner. Adverse event data is collated, analysed and reported to staff at the staff/quality meetings and minutes reviewed showed discussion in relation to any trends identified, action plans in place and any improvements made. The process undertaken by the nurse manager far exceeds the normal expectations and a continuous quality improvement has been raised for adverse event reporting. Policy and procedures described essential notification reporting requirements. There has been three Section 31 notices completed since the previous audit to HealthCERT. One related to RN cover, two recently for the notification of the new clinical nurse appointed and the total evacuation of the facility in response to the earthquake and tidal wave warning on 5th March 2021. The nurse manager and clinical nurse are fully informed of what agencies to report to when a serious event occurs.
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	Policies and procedures reviewed are in line with good employment practice and relevant legislation and guide human resources management processes. Job descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates where applicable. There is a process in place to record all health professionals who are contracted to the facility, in regards to their professional practising certificates that are renewed annually. A record was verified and is well maintained. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Most staff interviewed had been at the facility for some years. Staff records reviewed showed documentation of completed orientation. Continual education is planned on an annual basis. The education programmes for 2020 and 2021 were reviewed. Mandatory training requirements are defined and scheduled to occur over the course of the year. All care staff have either completed or have commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with the DHB. The nurse manager is

		responsible for the staff records and was interviewed. Of a total of 29 care staff 10 care staff have completed the New Zealand Certificate (NZC) Health Workers Advanced Support level four and three care staff have completed NZC Health assistance level 3. Ten care staff are level 4 by right and previous training completed and nine clinical and non-clinical have completed NZC Health and Wellbeing level 2. Six staff of 15 originally enrolled in level 2 have withdrawn. A senior caregiver is the education assessor for this service. Support is also provided for education from the primary health organisation and DHB aged residential care team who provided education for the registered nurses and care staff. Appraisals were current for all staff. All staff have completed and have current first aid certificates. Annual staff competencies were completed and the registered nurses, one enrolled nurse and the team leader who administer medicines have completed annual medicine competencies which were recorded.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of the residents. The roster is a permanent roster with staff set in shifts and set resident allocation. The nurse manager explained that this allowed for better outcomes for residents and better performance of staff who know the preferences and routines of their residents. The permanent roster ensures the right skill mix on the floor. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a six-week roster cycle sampled during the audit confirmed adequate staff cover has been provided. There is one registered nurse and three caregivers on night duty. At least one staff member on a shift has a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry	FA	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

To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. A family member of a resident interviewed reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Regular medication audits are completed and are followed with appropriate corrective actions, when necessary. There was evidence of pharmacy involvement. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-

		monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. There is a resident who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
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 food service is provided on site by a kitchen team of two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in 2020. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Whakatane District Council effective from 03/02/2021. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualifications. 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. Evidence of resident satisfaction with meals was verified by resident and family interviews, 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the registered nurses (RN) and clinical nurse. There is a clause in the access agreement related to when a resident's placement can be terminated.

Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents are assessed to develop an initial care plan. Within three weeks of admission, a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, depression scale and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents, except for residents who are needing care under palliative care funding, have current interRAI assessments completed by trained interRAI assessor 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	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. 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 care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
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	FA	The activities programme is provided by a team of two experienced activities coordinators. A wide range of activities are provided. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated as part of the formal six monthly care plan reviews. The weekly activities planner sighted matched the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are

the setting of the service.		involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they enjoy the programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and skin tears. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and disability service providers. Although the service has a contracted GP service, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the eye clinic, mental health for older people and orthopaedic clinic. 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or	FA	Documented processes for the management of waste and hazardous substances were in place and are closely linked to the risk management system and health and safety. A contracted service is responsible for collecting waste. A waste management audit was completed in February 2021. The hazardous substance register was up-to-date and signed off by the nurse manager. The hazard register covers all chemicals used, care provision hazards, outside the premises hazards, laundry and cleaning hazards and any kitchen hazards. Health and safety training was provided for all staff. There is a designated health and safety officer. The doors to the areas storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff.

hazardous substances, generated during service delivery.		Material safety data sheets were available where chemicals are stored and staff interviewed knew how to access information if needed. A spills kit is available should an event occur. Any related incidents are reported in a timely manner. There is adequate provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this including gloves, goggles, masks and gowns as needed. The manager is responsible for ensuring adequate stocks of PPE are ordered and available for staff at all times. A cupboard is available with stores of PPE resources for use in the event of an infection pandemic.
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 building warrant of fitness expires 1 June 2021 and was publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Significant improvements have been made to the inside of the facility and to the outside since the previous audit including a new roof for the building. Golden Pond Private Hospital is well maintained and rooms are upgraded as necessary and when vacated. An equipment audit was completed in October 2020. A checklist for all areas of service provision is checked by the health and safety representative on a monthly basis. External areas are fully maintained and appropriate to the resident group and setting. The environment is conducive to the range of activities undertaken in the designated areas. The environment was hazard free and residents were safe. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance are required, that any requests are appropriately actioned and that they are happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance	FA	There is a mix of toilet, showers and bathing facilities. There are adequate numbers of accessible bathrooms and toilets throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Staff and visitor toilets are available. Toilets and showers are clearly identifiable. Every resident's room has a hand basin. All surfaces are easily cleaned. There is also a shower for staff to use when pandemic restrictions are in place. There is a bed-bath bathroom available if needed. There are eighteen ensuite bathrooms, 10 showers and toilets and five separate toilets. The nurse manager tests the hot water at the tap ensuring the water is maintained at a safe temperature and this is recorded monthly.

with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around freely within their bedrooms safely. Rooms are personalised with ornaments, photographs and other personal items displayed. There is adequate space to store and to use mobility aides, walking frames, a hoist and wheelchairs. Staff and residents reported adequacy of individual bedrooms. On visual inspection, all furnishing are provided with residents having some of their own furniture of choice. Any furniture not used is stored appropriately.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are communal areas available for residents to engage in activities. There are three main lounges and two dining areas that are spacious and enable easy access for residents and staff. There is a separate dining area for residents in the units to utilise for meals and activities. A whanau lounge and another small area can be used for activities or for families when they visit. A large screen television is available in the main lounge and comfortable seating. Furniture is appropriate to the setting and residents' needs. Bookshelves are evident with ex-library books for residents to access anytime in the small lounges. There is a large area at the front of the facility which has a goldfish pond where residents can sit close-by and enjoy the outside. In addition to this, there are two small shaded areas for residents to enjoy externally with appropriate seating.
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	FA	All laundry is undertaken on site by designated laundry staff who cover the service seven days a week. The two staff alternate the weekend cover. Personal clothing, blankets and bedcovers are laundered onsite, and a contracted service provider is responsible for all towels, sheets, pillowcases. Residents interviewed reported that laundry is well managed and their clothes are returned in a timely manner. The laundry is set up appropriately to meet the needs of the residents. A high standard is met by staff. The laundry is divided into dirty and clean areas for infection prevention and control purposes, is well ventilated, clean and tidy. Personal protective resources are readily available for all staff and adequate stocks are always available. There are combined policies and procedures for the laundry and cleaning which meet infection control standards. There is a small separate laundry for washing the kitchen laundry and laundry from residents' in the 11 studio units.

provided.		There are three cleaners who work Monday to Friday. One cleaner works the weekend and covers the whole facility ensuring the facility is well maintained. Each cleaner staff member has their own allocated wing during the weekdays. One cleaner is responsible for ordering the supplies needed for both the laundry and the cleaning. The laundry product use system is currently transitioning to an auto-system and chemicals will go directly into the washing machines. Material data sheets are available and accessible as needed. The products for cleaning are wall mounted and refillable dispensers work effectively when refilling the labelled cleaning containers. The chemical contracted company representatives provide education for staff on a regular basis and ensure products used are monitored for effectiveness. The cleaners use colour coded micro-fibre cloths for cleaning. Carpet cleaners are contracted and clean carpets as necessary approximately every two months as per the schedule sighted. The cleaning trolley is locked in the laundry when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for all emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe 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 07 July 2006 and remains operative. A trial evacuation takes place six monthly with a copy of the drill sent to the New Zealand Fire Service, the most recent drill being the 17 November 2020. The orientation programme for all newly employed staff includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures and verified that they have all received appropriate training for all types of emergency situations. This training was put into action on the 6th March 2021 when the region had sustained several earthquakes during the night and in the morning at 8.36 am a tsunami alert to move to higher ground was put in place. The service has been awarded a continuous improvement rating for the way they managed this significant emergency situation. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, torches, batteries and a gas barbecue were sighted and meet the requirement for 61 residents. All water bottles have been replaced this year. Water supplies meets the requirements of the local Council for emergencies. Emergency lighting is available and this is checked monthly. There is no generator on site but provision for hire is available if needed. All emergency supplies are checked regularly with one large bin also being available in a store cupboard, with all emergency resources needed in an emergency. Call bells alert staff to residents requiring assistance. A new Wi-Fi call bell system has been installed since the previous audit and education was provided to all staff. Call bell system audits are completed on a regular basis and residents and families reported that staff responded promptly to call bells. Staff ensure the facility is locked at a predetermined time each evening and nursing staff do hourly rounds at night-time. Outside security lighting is available. Sensor door alarms are in place on all side doors.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The residents' individual rooms and communal areas have opening external windows. The resident's individual rooms have windows that open into the garden throughout this facility. There are external gardens in several areas between wings that are attractively maintained. There are electric thermostat heaters for winter located in the hallways, main lounge and dining areas which work effectively for the large open spaces. Fans are used in the summer months. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimises 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 annually. 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 FM and tabled at the staff meeting. This committee includes the facility manager, clinical nurse and IPC coordinator. 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. Due to the Covid-19 pandemic all visitors are requested to log their visit by entering their details on a paper log or by scanning a Ministry of Health bar code. 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.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and	FA	The current IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for since January 2021. The current IPC coordinator is supported by the experienced clinical management team. The IPC coordinator attended trainings including training on usage of PPE, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There were no infections disease outbreaks reported in the facility since the last audit.

meet the needs of the organisation.		
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are currently being reviewed and include appropriate referencing. 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Hand washing and donning doffing of personal protective equipment trainings have been completed as a part of recent pandemic preparedness. Health education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed	CI	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, respiratory tract and other infections. 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. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required

objectives, priorities, and methods that have been specified in the infection control programme.		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. Data is benchmarked internally and compared against previous year's data. This comparison has provided assurance that infection rates are lower than last years. Covid-19 pandemic preparedness document is sighted, and staff interviewed were aware of this plan.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in this facility and demonstrated a sound understanding of the organisations policies, procedures and practice. The experienced enrolled nurse (restraint coordinator) interviewed has a job description for this role and responsibilities are clearly outlined. On the day of the audit, five residents were using restraints and five residents were using enablers, which were the least restrictive and used voluntarily at their request. The service has a robust process, which ensures the on-going safety and well-being of the resident. Restraint is used as a last resort when all alternatives have been explored. The annual restraint review was recently performed January 2021.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group made up of the clinical nurse, enrolled nurse, GP and nurse manager, are responsible for the approval of the use of restraints and the restraint process, as defined in policy. It was evident from review of restraint approval group meeting minutes, review of resident's records and interview with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved and the overall use of restraints is being monitored and analysed. The restraint coordinator reviews all restraint records six monthly and this is overseen by the nurse manager. Evidence of family involvement in the decision making, as is required by the organisation's policies and procedures, was on record in each case reviewed. Use of a restraint or an enabler is included in the care planning process and documented in the plan of care.
Standard 2.2.2:	FA	Assessments for the use of restraint were documented and included all requirements of the Restraint Minimisation and Safe Practice Standard. The initial assessment is undertaken by a registered nurse with the

Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.		restraint coordinator's involvement and input from the resident's family. The enrolled nurse interviewed described the documented process. Families interviewed confirmed their involvement. The GP has involvement in the final decision on the safety of the use of a restraint and this was verified in the individual records reviewed. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the residents' safety and security. Completed assessments were sighted in the records of residents who were using a restraint. Bedrails were the only restraints used as per the records reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised. The restraint coordinator described the alternatives to restraints which are discussed with staff and family members. In the last year the service has focused on minimising restraints and strategies such as purchasing 15 ultralow beds and a further 15 additional low beds have also been purchased and implemented. The use of sensor bed mats and floor mats and landing strips for other residents who otherwise need restraint are now available. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe at all times. Records contain the necessary details and confirmed that access to advocacy is provided if requested and all processes ensure dignity and privacy. A restraint register is maintained and was current and up to date. The register contained all relevant information required to meet the standard. Staff have received training on all policies and procedures in place for restraint minimisation and safe practice. Policies in place to manage and guide staff on management of disturbed behaviours and the principals in managing behaviours of concern were available for the documentation review. Staff are educated to de-escalate situations and to have strategies in place as needed. These are updated in the resident's care plans if relevant to a resident along with techniques to manage different situations as they arise. Staff interviewed understood the use of restraint was to be minimised and how to maintain safe use was confirmed. Restraint was only used as a last resort.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' records evidenced the individual use of restraints is reviewed and evaluated during the six monthly interRAI reviews and the updating of the care plans. This is documented at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation includes all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedures were followed and documentation completed as required.

Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint approval committee and the restraint coordinator undertake a six monthly review of all restraints which includes all the requirements of the Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families. A six monthly internal audit that is carried out also informs these meetings. Any changes in policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes of meetings, interviews with the nurse manager, the restraint coordinator and other staff confirmed that the use of restraint has been reduced by three over the last year.

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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	CI	All complaints, both verbal and written, are documented on the complaints register. Complaint forms are readily available at reception should residents/families/staff have any concerns or compliments. The nurse manager records any feedback as part of the complaints process and for quality improvement purposes. The register records complaint identified, date acknowledged and if an advocate is involved. The complaints are reviewed in a timely manner and responded to and all complaints can be followed through with all action undertaken and outcomes being clearly documented and dated. One of the two HDC complaints was actioned immediately by the nurse manager and despite the HDC process being ongoing positive action was commenced immediately. The follow through has been well documented to a high standard. Complaint outcomes are discussed at the quality/care staff	Having fully attained the criterion the service can in addition clearly demonstrate that the nurse manager with support of the clinical staff have, in addition to adhering to the complaints process in place, have confirmed ongoing improvements in service provision in relation to an HDC complaint received in 2019. The manager and staff reported the prompt implementation of further manual handling and hoist training and more accurate documentation of any events that occur. The RNs had a refresher on reporting requirements despite a comprehensive documented adverse event policy and procedure being in place. RNs reported after further evaluations of the new processes that had been introduced, that a more robust system exists, awareness has increased and resident safety and wellness has greatly improved with the increased knowledge obtained for all staff. The use of additional assessment documentation has been beneficial for residents requiring medical attention or a transfer to the DHB and the

		meetings where applicable. Feedback is also provided to individual residents/family who have complained. From one of the HDC complaints (2019) some positive changes have taken place including the registered nurses only completing documentation and responses when the general practitioner (GP) is notified for advice. A falls risk assessment has been reviewed, redeveloped and implemented and is used in conjunction with the interRAI assessment. All staff completed further training in resident handling and hoist management competencies and an education following-up the resident handling procedure was in turn revised and updated. An 'SBARR' communication tool was introduced to be used when staff are ringing through to the general practitioner and/or if transferring a resident to the DHB. All changes implemented were evaluated on several occasions and discussed at the RN and care meetings. Any progress or outcomes of discussion was documented in the minutes from the meetings held since the complaint was received.	registered nurses reported on the success of this action.
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to	CI	Golden Pond Private Hospital's nurse manager collates all statistics from all incidents that occur on a monthly basis including any skin tears, falls, pressure injuries, wounds, wandering residents, abuse, near misses and any medication errors or other events that may occur. This information is analysed and benchmarking occurs with a group of five regional aged care facilities – like services on a monthly basis. In July 2019, training was provided for all registered nurses (RNs) on end user access to the interRAI which enables access to the interRAI programmes, such as the wound care plans. All incidents of wounds, bruises, rashes, lesions or pressure injuries were entered into the interRAI	Having fully attained the criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken. Improvements are demonstrated related to service provision, residents' safety and/or satisfaction as a result of the review process. The linkage between the incident management system and the interRAI programmes is evaluated regularly and evidences a significant achievement for management and staff. The residents' have benefited with the positive outcomes and increased resident safety. The event reporting as described above is comprehensive and assists the clinical leader and registered nurses to make appropriate choices around the follow-up care, leading to a management and implementation plan. Families are always, with consent of the resident, kept

identify and manage risk.		programme by the RNs. For accuracy reasons staff ensured the event was upgraded each time they observed/assessed (e.g., a wound). This data improvement system now in place reliably records all active wounds in each area of the hospital. Reports are produced monthly and information is evaluated and reported at the quality/care meetings. The actual completed resident incident forms are filed in the individual resident's records and other incident forms not related to residents are filed in the incident folder under headings, such as general incidents, staff, medication and others. The incident register highlights the incident, follow-up, action and any recommendations.	well informed of any incidents occurring and progress (e.g., for wound care management) and/or new strategies in place if needed.
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	CI	All staff had received emergency management and evacuation education at orientation and on an ongoing basis. Apart from the regular six-monthly fire evacuation drills, no other emergency situation has been activated at this home. On 6 March prior to this audit, the region suffered three earthquakes during the night. Staff during the night reassured residents as needed throughout this event. Soon after staff shift handover occurred in the morning at 8.36am the Civil Defence Siren was heard and an alert was received to move to higher ground. The emergency protocol was implemented immediately in a well organised manner. Staff followed instructions of senior registered nurses and management. Staff systematically got residents out of bed and into wheelchairs and lazy boy electric wheelchairs. Residents were grouped in the lounges in ability groups ready for evacuation. During this time the kitchen staff prepared food from emergency stores, disposable cups and plates ready to transport. Senior staff contacted a rest home with whom they have a memorandum of understanding (MOU) with to	Having fully attained the criterion the service can in addition clearly demonstrate an initial review process including analysis and reporting of findings, evidence of action taken and based on those findings found that a positive outcome from this emergency situation provided invaluable feedback for staff, family, residents and members of the community in handling such a significant evacuation in a safe manner. No injuries were sustained with any residents or staff. Contact was maintained regularly with families, Civil Defence and a DHB representative phoned regularly. The New Zealand Fire Service (the fire service rang to assist with transferring a 200kg resident plus the wheelchair into their fire service van). Once all residents were located at the rest home, staff made refreshments for the residents. At the first evacuation centre the local supermarket arrived with food for the residents. The nurse manager and staff were humbled by the calibre of the people who volunteered assistance and the staff throughout this evacuation process. From debriefing with staff and others involved and reviewing the situation, the nurse manager documented areas that were a problem and what was done efficiently and well. The residents' feedback was also taken into account, such as comments that they were well treated, managed carefully and felt safe

		advise of the evacuation to this home. This home was already being evacuated to Kawerau. A total mobility hoist company was contacted for a transport bus. Staff were informed this would be delayed to concentrate on those residents that could be moved at that time safely. The clinical nurse maintained a register of where residents had been evacuated to. A walking line was commenced with light wheelchairs and electric chairs being used for residents. These resident were walked some distance by staff members and with some public support to the rest home. This rest home was confirmed with Civil Defence as being appropriately distanced from any tsunami at the current time. During this time, an RN packed medication into containers. Residents were also lifted into staff vehicles. The total mobility van was used for the more immobile residents. Off duty staff and people from the community arrived to assist. Five very heavy dependent residents were able to be loaded onto a trailer via a ramp and were taken to another higher ground location. The nurse manager took the resident emergency folder with name tags and care plans. In one hour, 61 residents were evacuated.	throughout this evacuation process. Feedback from family members reviewed confirmed appreciation and all were grateful for the assistance, reassurance and the organised manner for such an emergency situation. Another debrief had already been arranged with all concerned.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and	CI	In 2018, Golden Pond Private Hospital initiated a quality initiative to reduce antibiotic usage for urinary tract infections (UTI) among elderly residents. Residents were encouraged to keep hydrated and residents were monitored for early signs of dehydration. Any residents with signs of dehydration were encouraged to drink more fluids and were treated based on their symptoms. For example, residents with concentrated urine were treated with ‘ural’ sachets. Resident are treated with antibiotics for a UTI only if they met ‘McGreer’s criteria’ which	There has been a significant reduction in number of UTIs among resident in Golden Pond Private Hospital following a systematic quality improvement initiative/project. The number reduced from 30 to 8 UTIs per year since 2018.

prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.		includes positive urine laboratory results along with more than two signs of a UTI. This has resulted in reduced UTIs.	

End of the report.