

# Claud Switzer Memorial Trust Board - Switzer Residential Care

---

## 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 BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	Claud Switzer Memorial Trust Board
<b>Premises audited:</b>	Switzer Residential Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 10 August 2021 End date: 11 August 2021
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	91

# 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

Switzer Residential Care provides rest home, hospital, and dementia level of care for up to 92 residents. On the day of the audit there were 91 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, and the general practitioner

The trust board employs a chief executive officer (RN), a facilities manager, a human resources manager, and two nurse managers to implement the strategic plan and oversee the day-to-day operations of all services. All managers are well qualified for their roles. There are well developed and implemented systems and policies to guide appropriate quality care for residents. A quality programme is being implemented. An induction programme and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care. The residents and relatives spoke very positively about the care and supports provided at Switzer residential care.

There were improvements identified around performance appraisals, interRAI assessments and medication competencies.

## 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.
--	--	--

Switzer Residential Care provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy, and informed consent.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## 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.
---	--	---

Switzer Residential Care has implemented a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly quality assurance meetings. An annual resident satisfaction survey is completed and there are monthly resident meetings. Quality performance is reported to staff

and includes a summary of incidents, infections, and internal audit results. There is a health/safety and risk management programme in place.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is sufficient information gained through the initial support plans, specific assessments, and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident, and goal orientated and reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified that the integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review.

The activities team implements a varied activities programmes to meet the individual needs, preferences, and abilities of the residents. Community links are maintained. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and enrolled nurses who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified on admission and all meals are cooked on-site. This includes consideration of any particular dietary preferences or needs.

## 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.
--	--	--

There is a current warrant of fitness and an approved fire evacuation plan. There is at least one staff member on each shift with a first aid certificate. Rooms are single accommodation with the exception of one double room in kowhai wing. Bedrooms in three wings have their own ensuite. There are adequate communal toilets and showers.

The home is warm and resident rooms are personalised. There is a large central lounge area and a spacious dining room in the main hospital/rest home and dementia areas. There are effective waste management systems in place and chemicals are stored safely. The facility has two minibuses available for transportation of residents, one being wheelchair accessible. Staff that transport residents hold current first aid certificates.

Dedicated staff manage cleaning and laundry services. There are systems in place for emergency management and there is at least three days of emergency supplies stored on-site. Solar heating supplies the dementia wing with heated wall panels throughout the facility and underfloor heating in two wings. The facilities manager monitors internal temperatures. There is a designated smoking area within the grounds.

## 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.
---	--	--

There is a documented definition of restraint and enablers that align with the definition in the standards. There is a restraint register, which also records residents who require the use of an enabler. The restraint approval process is undertaken with the resident, family, and other health professionals. All parties sign restraint consent forms. The use of enablers is clearly described in policy and procedure, to be used on a voluntary basis and to help them maintain physical and/or psychological independence. On the day of audit there were eight residents with restraint and 14 residents with an enabler. Staff receive training in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (nurse manager) is responsible for coordinating education and training for staff. The infection control coordinator (ICC) has completed annual training provided internally and has access to external training provided by the local DHB. There is a suite of infection control policies and guidelines available to support practice. The ICC uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks since the previous audit.

## 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	47	0	1	2	0	0
Criteria	0	98	0	1	2	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Interviews were held with the following managers (chief executive officer, Human Resource (HR) manager, facility manager, two nurse managers) and staff (six caregivers [care partners], five registered nurses (RN), two enrolled nurses (EN), cook, one activities coordinator, diversional therapist (DT), training coordinator, administrator/quality coordinator, supervisor cleaning and laundry, operations manager (kitchen) and consultant to the facility manager. All confirmed their familiarity with the Code.</p> <p>Training around the Code, advocacy, informed consent, privacy, and elderly abuse are part of the mandatory training day that staff undertake. These are offered during the year and staff are required to attend one session.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in ten resident files, two dementia, five hospital (including one YPD and one LTS-CHC) and three rest home were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Care partners and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care. Discussion</p>

information they need to make informed choices and give informed consent.		with family members stated that the service actively involves them in decisions that affect their relative's lives. Ten resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code and Advocacy pamphlets on entry. Interviews with the general manager and nurse manager confirm practice. Residents interviewed confirm that they are aware of their right to access advocacy. Discussions with relatives confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks. Staff receive education and training on the role of advocacy services. The nationwide advocate visits the service annually and as required and observes care and support provided.
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	Interview with residents and relatives confirmed that relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Residents interviewed confirm the activity staff help them access the community such as going shopping, going on sight-seeing tours, and going to church. Residents identified as under a Young Person with a Disability (YPD) contract and are engaged in a range of diverse community activities including health and wellness, social groups, and community outings. The main doors lock at dusk. Family are able to ring through to the service using the two main entrances if they wish to visit after hours.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice. The Chief Executive Officer (CEO) leads the investigation and management of complaints (verbal and written). There is a complaint (and compliments) log/register that records activity in an ongoing fashion. Complaints are discussed at the monthly meetings. Complaints forms are visible around the facility on noticeboards.  There were six complaints in 2020. One was lodged by the Health and Disability Commission in November 2020. The complaint is still open. There has been one complaint made in 2021. Three complaints reviewed during the audit confirmed that these had been responded to, investigated, and closed out in a timely manner with the complainant offered advocacy services should they not be satisfied with the outcome.  Discussion with residents and relatives confirm they are aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the nurse manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</p> <p>Interviews were held with 15 residents (eight rest home and seven hospital), and six family members (four rest home, one dementia, and one hospital). All confirmed the services being provided are in line with the Code. Other family members from the dementia unit were not able to be contacted on the day of audit however observations showed that practice was in line with the Code.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Resident files and care plans identified residents' preferred names.</p> <p>Care partners were observed to knock on doors before entering resident bedrooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and relatives interviewed during the audit confirmed that the residents' privacy is respected.</p> <p>The residents' personal belongings are used to decorate their rooms as observed on the day of audit.</p> <p>Resident's cultural, social, religious, and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives</p> <p>Information around values and beliefs is gathered on admission with family involvement and is integrated into the residents' care plans. Training around privacy and dignity has been provided annually as part of the core training day held.</p> <p>There is a policy around abuse and neglect. Staff receive training around abuse and neglect. Care staff interviewed are able to discuss ways in which they would manage suspected abuse or neglect. Staff, managers, and the general practitioner (GP) interviewed confirmed that there is no evidence of any abuse or neglect. Residents are supported to attend church services of their choice and are offered spiritual services weekly/monthly.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>Switzer Residential Care has a Māori health plan that is reviewed at least annually. There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. The service has as a quick reference flip chart (Tikanga Recommended Best Practice</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>Standards/Guidelines) in place that provides guidance for staff on culturally acceptable practice.</p> <p>Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. There are kuia and kaumatua who come into Switzer to meet with residents and to facilitate activities that include flax weaving and other cultural activities. The group represent a number of different marae. There are kuia on the Switzer Home Auxiliary who assist with fundraising for Christmas and Birthday gifts.</p> <p>Staff in the service link with a large number of community groups including Te Hauora O Te Ika for doctor and nurse practitioner services, Maori representation on the advisory group to the board and a trustee on the board who identifies as Maori (Ngati Kahu).</p> <p>There are currently 35 Maori residents with equivalent numbers of staff who identify as Maori. Some are able to speak fluent te reo and others have conversational te reo. Three residents who identified as Maori stated their cultural needs were met with any cultural needs documented in assessments and in care plans (link 1.3.3.3).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform that values and beliefs are considered. Residents interviewed confirm that staff consider their culture and values.</p> <p>One resident who identified as Pacific complimented the service on the 'family way' of the service and noted that specific activities were provided to include family and a Pacific focus.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The employee agreement provided to staff on induction includes standards of conduct. Staff have had training around professional boundaries in 2021.</p> <p>Residents and the family members interviewed stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the</p>

		previous 12 months relating to any form of discrimination or exploitation.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Switzer Residential Care has a suite of appropriate policies and procedures that are updated as necessary. There is an established quality improvement programme that includes performance monitoring against clinical indicators.</p> <p>Switzer Residential Care is part of the Far North Quality and Benchmarking Group and although the membership has decreased to two services since Covid 19 pandemic, the organisation has a continued commitment to reaching targets.</p> <p>There is a training coordinator (RN) who facilitates training options for staff. This has meant that staff have a variety of ways they can access training that includes on-line, face to face and questionnaires against policies. There is evidence of education being supported outside of the bi-annual training plan such as palliative care training for HCAs and attendance at in-service offered via the DHB. There is a 'train the trainer' programme in place that includes a 16-week in-service programme, the HCAs spoke very positively about the programme.</p> <p>The Eden Alternative and proactive empowerment of residents continues with staff continuing to embrace the principles of the model and philosophy of care.</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>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Of the 27 incident forms reviewed, all identified that family were notified following a resident incident. Interviews with care partners, RNs and ENs confirmed that family are kept informed.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and this can be read to residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>Switzer Residential Care provides care for up to 91 residents across three service levels (rest home, hospital, and dementia care). The 91 beds comprise of 25 designated rest home beds; 30 designated hospital beds; 21 dual-purpose beds; and 15 designated dementia beds. The facility is split into five wings, the Puriri wing (dementia care) has 15 of 15 residents, Kauri wing (rest home) has 20 of 20 residents, Millie wing (dual-purpose beds) has 15 of 16 residents, Kowhai wing (hospital) has 24 of 24 residents and Matai wing (dual-purpose beds) has 17 of 17 residents. On the day of audit there were 91 residents in total: 32 rest home level residents, 44 hospital level residents and 15 dementia care residents. The majority of residents are on the aged residential</p>

<p>appropriate to the needs of consumers.</p>		<p>related care (ARRC) contract except for four YPD residents (one rest home and three hospital). Nine rest home and eight hospital private paying residents; and two long term support – chronic health conditions (LTS-CHC) including one with hospital level of care and one in the dementia unit.</p> <p>Switzer Residential Care is a charitable trust with a board of three trustees (pharmacist, doctor, and one with a business background who identifies as Ngati Kahu. There is an advisory group (that includes iwi representation, representatives from social services, NGO's, and key supports for residents in the community e.g. WINZ and Masonic Lodges. The advisory group meets with the board of trustees four times a year.</p> <p>There is a strategic plan (2019 – 2039) that includes long-term goals, vision, mission, and philosophy. Goals include critical success factors and outcomes. There is an annual business, quality improvement and risk management plan that details all aspects of the quality programme. Benchmarking is undertaken as part of the Far North Quality &amp; Benchmarking Group.</p> <p>The service is managed by an experienced chief executive officer (registered nurse) who reports to the Board. The chief executive officer has been in the role for 19 months, has 13 years management in aged care, and has the following qualifications: MBA, Graduate Certificate in Management, Management and Leadership in Nursing Practice, post graduate certificate in Health Sciences, and a Diploma in Business Accounting. The chief executive officer is supported by the HR manager who has been in the role for eight years, two nurse managers who both have extensive experience in aged care services, and the facilities manager who has been in the role for one month. The facilities manager is currently being supported and orientated by the previous facilities manager. There are a team of RNs who have experience within the aged residential care environment.</p> <p>The chief executive officer and the nurse managers have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the facilities manager and nurse managers will cover the CEO role (and vice versa). Both the CEO and nurse manager are experienced RNs. The RNs and facility manager were able to describe their role if they relieved for the chief executive officer.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Switzer Residential Care is implementing a quality and risk management system. The organisational business plan and quality plan include quality goals with these reviewed through the range of meetings held in the organisation. There is an organisational risk management plan for 2021. All plans were reviewed at the end of 2020 prior to new plans being developed.</p> <p>The management team is responsible for implementation of the quality and risk management programme with the CEO providing oversight of the quality programme. The quality coordinator has a background in education and has been in the role for five weeks. They will oversee the implementation of plans and the quality programme. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. A document control process is well established.</p> <p>The annual residents/relatives survey for the service was last completed in August 2020. There were 51 respondents out of the 102 sent out. Ninety percent of residents and family were very satisfied with the service and 10 percent were satisfied. There were no real issues or suggestions raised in the report.</p> <p>The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans with evidence of resolution of issues as these are identified.</p> <p>Monthly and annual analysis of results is completed and provided to staff and to the board. There are monthly accident/incident reports that break down the data collected across the different levels of care. Infection control is also included as part of benchmarking across the organisation. There are a range of meetings where data is tabled. This includes the three to four monthly staff, monthly quality, monthly health, and safety, head of department meetings, clinical meetings daily with a registered nurse meeting monthly. The meeting minutes show that quality improvement data is collected, analysed, and evaluated and the results communicated to staff and others. Minutes of these meetings are made available to all staff.</p> <p>Resident/relative meetings are held weekly. The Resident Association also meets monthly with the DT facilitating the meeting. Meetings are minuted.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. The service has rewritten much of the health and safety manual to reflect the changes to legislation. The contractor policy now requires that the service holds specified contractor certificates of competence i.e. electricians and plumbers. A visual scorecard has been developed to display and inform staff about how the organisation is performing in certain strategic areas i.e. falls, staff injuries, call bell response times, specific projects/ concerns, and compliments.</p>
---	-----------	--

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident/accident data has been collected and analysed. Incident forms are completed by care staff and the resident is reviewed by the RN at the time of event. The form is reviewed by the nurse manager and forwarded to the CEO for final sign off. An RN conducted clinical follow-up of residents in all 27 incident forms reviewed and demonstrated investigation of incidents to identify areas to minimise the risk of recurrence.</p> <p>Interview with staff inform incidents/accidents are reported appropriately. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications were made to HealthCERT since the last audit for pressure injuries, a fracture and a resident who overdosed while on social leave.</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>There are human resources policies to support recruitment practices. Eleven staff files were reviewed. They were the facility manager, two nurse manager, three RNs, three care partners, one cook, and one diversional therapist. All had relevant documentation relating to employment including reference checks, a police check, job description and signed contract relevant to their role. A list of practising certificates is maintained.</p> <p>The service has an education coordinator who is responsible for ensuring the orientation programme is completed for new staff. There is a buddy system for new staff and staff interviewed stated that they had completed a robust orientation.</p> <p>There is a yearly education plan that includes all required education as part of these standards. The plan is coordinated by the education coordinator (RN). Compulsory study days are offered throughout the year and staff are required to attend one day annually. These days are called 'make it happen' and includes the following topics: moving and handling, falls prevention, fire evacuation/training, occupational health and safety, code of rights, infection control and resuscitation. Staff are able to make suggestions on additional topics for inclusion in the in-service calendar. There is evidence that additional training opportunities are offered to staff such as attendance at a palliative care series. Training attendance is recorded on a database (sighted), and the education coordinator undertakes a reconciliation of attendance annually. This process ensures staff are meeting compulsory requirements and from the information reviewed all staff have attended a 'make it happen' study day within the last year. The education coordinator works to find on-line resources for staff to tap into that enhances their learning. Performance appraisals were not current in all files reviewed.</p> <p>There is evidence on RN staff files of attendance at the RN training day/s and external training. A competency programme is in place with different requirements according to work type (e.g. care partner, RN, and kitchen staff). Competencies are completed and a record of completion is maintained in the database. Staff interviewed are aware of the requirement to complete competency training, however, not all medication</p>



		<p>competencies were current on the day of the audit (link 1.3.12.3).</p> <p>There are 51 care partners. Sixteen have completed the CareerForce (national certificate) level two; 26 have completed level three; and 12 have completed level four. Care partners who work in the dementia unit have either completed training or are in training (two currently). There are four care partners who are completing the health care assistance in aged care apprenticeship.</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>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The chief executive officer (RN with a current APC) and nurse managers alternate on-call. Staff in the dementia unit can push the panic button and this will alert staff in the rest home/hospital to provide support. There is a bed sensor for residents in the dementia unit that alerts staff if a resident is out of bed.</p> <p>The facility is split into five wings.</p> <p>Puriri wing (dementia care) has 15 residents (dementia): two care partners (long shift) and one kitchen hand (0800 to 1300) AM; two care partners (one long shift and one until 2100) PM; one care partner overnight. There is a registered nurse rostered on for two to three hours per day.</p> <p>Millie wing (dual-purpose beds) has 2 rest home and 13 hospital residents: 1 care partner (long shift) and 1 care partner (0700 to 1330) AM with an extra short shift from 0800 to 1430 Monday to Friday; 2 care partners (one long shift and one until 2100) as well as a one care partner 1330 to 1530 PM; 1 care partner overnight.</p> <p>Kauri wing (rest home) has 19 rest home and 1 hospital resident: 1 care partner (long shift) and 1 care partner (0700 to 1330) AM; 2 care partners (one long shift and one until 2100) PM; 1 care partner overnight.</p> <p>Kauri and Millie wings have an enrolled nurse between the two wings in the AM, and a registered nurse for on the AM and PM shifts (one in each wing) with a registered nurse on night shift between the two wings and a registered nurse for five to six hours between the wings on the AM shift.</p> <p>Matai wing (dual-purpose beds) has 10 rest home and 7 hospital residents: 2 care partners (long shift) and 2 care partners (0700 to 1330) and a kitchen hand (0800 to 1400) AM; 1 care partner (long shift) and one care partner (short shift); PM; 1 care partner overnight.</p> <p>Kowhai wing (hospital) has 1 rest home and 23 hospital residents: 2 care partners (long shift) and one care partner (0700 to 1300); 2 care partners (long shift) and 2 care partners (1515 to 2100) PM; 1 care partner overnight.</p> <p>Matai and Kowhai have an extra care partner who floats over both wings overnight to support staff. Matai and Kowhai have an enrolled nurse between the two wings in the AM, and a registered nurse for on the AM and PM shifts (one in each wing) with a registered nurse on night shift between the two wings.</p>

		<p>There is one registered nurse on duty overnight.</p> <p>Rosters for the past three months were sighted, and staff were replaced when on leave. The care partners, residents and relatives interviewed, inform there are sufficient staff on duty.</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>	FA	<p>The resident files are appropriate to the service type. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of the resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant care partner or RN including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The nurse managers screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The ten admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed state that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members report that the nurse managers or CEO are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and</p>

transition, exit, discharge, or transfer from services.		documentation required for a resident transfer out of, and admission into the facility.
<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>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit, who had been assessed as competent to self-administer by the RN and GP. The resident's room was visited and confirmation that the medications were stored securely obtained. All legal requirements had been met. There are no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and enrolled nurses who administer medications, have up to date medication competencies and there has been medication education in the last year. Not all care partners who administer and/or check medication had up to date medication competencies. Registered nurses have syringe driver training completed by the hospice. The medication fridges and room temperatures are checked daily. Eye drops viewed in the medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twenty medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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>	FA	<p>The regional operations manager (interviewed) of the corporate catering management company the service utilises oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring January 2022. Meals are plated in the kitchen and delivered straight to the main dining area and via hot boxes to the four wings, including the new kitchenette in the Kowhai wing. A tray service is available and delivered via a hot box system to maintain correct food temperatures. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily using an electronic management system. Food temperatures are checked at all meals. These are all within safe limits.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The six-weekly seasonal menu is approved by an external dietitian. Additional snacks are available at all times.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whanau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed (link 1.3.3.3), and 6 monthly reviews had been carried out as per policy for those residents who had been in the service for 6 months or more.</p> <p>Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provided detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietician, district nursing service and older person's mental health team. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included five chronic ulcers, fourteen skin tears, one grade 2 pressure injury (facility acquired), four cancerous lesions and two surgical wounds. The service liaises with the local district nursing service for complex wound management including vacuum dressings and compression bandaging when required for chronic wound management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. Behaviour monitoring is comprehensively documented in the dementia unit and elsewhere as required. De-escalation techniques are detailed in the care plans in sufficient detail to guide staff in caring for residents with behaviour that challenges.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist, and two activities coordinators covering Monday to Friday, who plan and lead all activities. The service designates weekends as family time, with resources set up and available for resident/family use. Volunteers also undertake some activities at weekends including concerts and religious services. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme given to each resident, which also has the week's menu on the reverse. This is also in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, men's club, prayer group, tai chi, crafts, games, quizzes, entertainers, pet therapy, bowls, and bingo.</p> <p>The diversional therapist highlights any activities that may not be suitable for those residents under 65 years of age and provides alternatives although a younger resident has the opportunity to attend any activity according to their preference.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are twice weekly outings including a supported shopping trip. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</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>Nine of ten resident files reviewed (excluding one recent hospital level admission) had evidence of a written evaluation by the registered nurses six-monthly or earlier if there was a change in health status. Activities plans are in place for each of the residents (including an individualised, age-appropriate plan for YPD resident) and these are also evaluated six-monthly. There is evidence of resident and family involvement in the review of long-term resident care plans against resident goals. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurse managers interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the nurse managers, and registered nurses identifies that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires June 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring July 2022. The hoist and scales are checked</p>

<p>with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>annually and are next due to be checked February 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and decked areas are well maintained. All external areas have attractive features and are easily accessible to residents. The dementia unit garden and grounds are safely and securely fenced. The indoor-outdoor flow off the lounge in the dementia unit allows unrestricted access to the garden area with raised beds and walking pathways. There is safe access to all communal areas in the facility, including the dementia care unit. All outdoor areas have appropriately placed seating and shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are five wings, Kauri, Kowhai, Puriri (dementia), Millie and Matai. All bedrooms in Kauri (rest home) have hand basins with the exception of one which has an ensuite. In Matai (dual-purpose) eight have ensuites, six have separate toilets and hand basins, and three have hand basins. In Millie (dual-purpose), 13 have ensuites and three have hand basins. Matai wing has eight bedrooms that have over the bed electric hoists. There are adequate communal toilets/showers available. Each bathroom has a hand basin and communal toilets have hand washing and drying facilities. There are soap dispensers in all bathrooms. There are separate staff/visitors' toilets. There is signage to promote effective hand washing techniques in the staff and visitors' toilet. There are hand sanitiser pumps available throughout the facility. The facility was clean, well presented and odour free. Residents interviewed reported their privacy is maintained at all times.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Doorways into residents' rooms and communal areas are wide enough for wheelchair, trolley, and bed access. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	<p>FA</p>	<p>There are large and small communal areas including large lounges in the hospital, dementia, and rest home areas. Activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry is done on site. There are clearly defined clean and dirty areas and entry/exit.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times when in use and locked away at other times. All chemicals on the cleaner's trolley were labelled. Residents and family interviewed reported satisfaction with the cleaning and laundry service.</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>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for more than 3 days for resident use on site. The service has its own emergency generator in case of power outage.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel, pagers and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night, there is CCTV in communal areas, entrances and there is security lighting externally. A local security company checks external doors as part of a night patrol.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled with staff and residents interviewed, stating that heating and ventilation within the facility is effective.</p>



<p>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>There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (nurse manager) is an RN who is responsible for infection control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Covid sign in and declarations are mandatory for visitors and contractors. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the last audit.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE. During Covid-19 lockdown it was mandatory for staff not to travel to and from the facility in uniform, with laundry and changing facilities provided on site. Although this is no longer mandatory, it is still available and strongly encouraged as being best practice.</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>There are adequate resources to implement the infection control programme at Switzer Residential Care. The infection control coordinator liaises with the quality/ infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of the monthly quality meetings and also as part of the registered nurse meetings. The infection control coordinator has completed annual training in infection control through the local DHB.</p> <p>External resources and support are available through external specialists, microbiologist, GP, district nursing service and DHB when required. The GP and pharmacist monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the facility management team, building upon a bought in system to make them site specific.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating education and ensuring staff attend education in-services. Training on infection control is included in the orientation programme. Staff have completed infection control education including Covid specific topics in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme, and the purpose and methodology are described in the Switzer Residential Care surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the registered nurse, and quality meetings. Meeting minutes are available to staff.</p> <p>Trend analysis is undertaken, and corrective actions are established where trends are identified. Monthly and</p>

		<p>quarterly infection control reports are submitted to the Board via the CEO.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</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 minimisation and safe practice policy outlines the process that staff should follow before enablers are implemented and includes identifying at risk behaviours, assessment procedures, alternatives and de-escalation techniques, discussion with multidisciplinary team, client and family/whānau, development of an enabler care plan, monitoring, reduction, removal, and evaluation of enablers. The assessment process ensures enablers are voluntary and the least restrictive option. On the day of audit, there were eight hospital residents with restraints (bed rails) and 14 residents using an enabler (bed rails). Staff training has been provided around restraint minimisation and challenging behaviours in 2021.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Responsibilities and accountabilities for restraint are outlined in the restraint minimisation and safe practice policy that includes responsibilities for key staff at an organisational level and a service level. The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. Individual approved restraint is reviewed at least three-monthly and presented at the quality meeting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two restraint and one enabler file were reviewed. The files sampled identified that a restraint assessment, discussion with family/whānau and consent form were completed for the two residents requiring restraint and an enabler assessment and consent form is completed for the one resident requiring an enabler. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>

restraint.		
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The files reviewed of residents requiring restraint have been evaluated three-monthly. Family/whānau participates in evaluations and at the residents' contract and care review meeting. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). Restraint practices are reviewed on a formal basis in the staff meetings and health &amp; safety and infection control committee. A restraint evaluation is completed of the restraint care plan three-monthly. Evaluation timeframes are determined by risk levels. Family/whānau is involved in review at residents' contract and care review meeting.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The files reviewed of residents requiring restraint have been evaluated three-monthly. Family/whānau participates in evaluations and at the residents' contract and care review meeting. Use of restraint is discussed at monthly staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). Restraint practices are reviewed on a formal basis in the staff meetings and health &amp; safety and infection control committee. A restraint evaluation is completed of the restraint care plan three-monthly. Evaluation timeframes are determined by risk levels. Family/whānau is involved in review at residents' contract and care review meeting.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Approved restraint for each individual is reviewed at least three-monthly by the restraint coordinator and as part of the annual contract and care review meeting with family/whānau involvement. Restraint usage across the facility is monitored monthly and discussed at monthly staff and health and safety and then to the QA meeting. An annual quality review of restraint usage is completed by the general manager. An internal audit for restraint usage was done in 2021.</p>

## Specific results for criterion where corrective actions are required

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

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

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

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	There is an annual education plan which includes all compulsory education sessions. Employment processes are implemented, however, not all files evidence annual appraisals have been completed.	Seven of the staff files reviewed did not evidence completion of an annual performance appraisal	<p>Ensure that all staff complete an annual performance appraisal</p> <p>180 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Moderate	Medication training has occurred annually. All registered nurses and enrolled nurses have current medication competencies, however, not all care staff administering or checking medications had current medication competencies.	Care partners who administered and/or checked medications did not have up to date medication competencies.	<p>Ensure all staff who administer and/or check medications have been assessed as competent to do so.</p> <p>30 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>All ten resident files reviewed had a documented long term care plan using the organisation's template, however new interRAI assessments were not completed within the required timeframes.</p>	<p>Four of ten files (2 hospital and 2 rest home) did not have initial interRAI assessments completed within 21 days of admission.</p>	<p>Ensure all new interRAI assessments are completed within the required timeframes according to policy</p> <p>90 days</p>
--	------------------------	--	--	--

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.