Kaylex Care (Waipukarau) Limited - Mt Herbert House

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:	Kaylex Care (Waipukarau) Limited
Premises audited:	Mt Herbert House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 December 2021 End date: 15 December 2021

Proposed changes to current services (if any): The provider intends building a 10-bed extension onto the existing facility in 2022. The extension will be for hospital level residents with complex needs.

Total beds occupied across all premises included in the audit on the first day of the audit: 37

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

Mt Herbert House is certified to provide rest home and hospital level care for up to 42 residents. The facility is owned by Kaylex Care (Waipukurau) Limited and is managed by a facility manager with support from a clinical nurse manager and the general manager.

Residents and families reported high satisfaction with the care provided.

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

The chalets that were certified from the previous audit have not gone ahead as it was deemed impractical to meet the New Zealand Fire Service requirements.

HealthCERT has requested comments under several standards relating to a complaint investigation by the Health and Disability Commissioner that has been closed.

There are no areas requiring improvement from 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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Kaylex Care (Waipukurau) Limited - Mt Herbert House. At the time of admission opportunities to discuss the Code, consent and availability of advocacy services is provided and thereafter as required.

Services at the facility are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families/whanau is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained. There have been no complaints received by the facility manager and no investigations by external agencies since the previous audit. The complaint investigation mentioned in the general overview above was included in the previous audit report.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Kaylex Care (Waipukurau) Limited is the governing body and is responsible for the services provided. The business plan includes a vision, values, philosophy, objectives and goals. Quality and risk management systems are fully implemented at Mt Herbert House and documented systems are in place for monitoring the services provided, including regular reporting by the facility manager to the general manager.

The facility is managed by a suitably qualified and experienced manager who has been in the position since 2012. The general manager supports the facility manager and clinical nurse manager. The clinical nurse manager is responsible for the clinical service.

An internal audit programme is in place. Adverse events are documented on accident/incident forms electronically. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff and residents' meetings are held on a regular basis.

Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place and followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. The facility manager is on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated hard copy and electronic hard copy files.

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.

Mt Herbert House works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families/whanau interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is provided by a diversional therapist and an activity assistant and provides residents with a variety of individual and group activities. When Covid-19 restrictions permit, links with the community are maintained. A hired van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Registered nurses administer medications, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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.

A building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Bedrooms provide single accommodation. Adequate numbers of bathrooms and toilets are available. Lounges, dining areas and alcoves are available. Shaded, external areas and seating are provided.

An appropriate call bell system is available, and residents and families reported timely responses to call bells. Security and emergency systems are in place. Staff are trained in emergency procedures and emergency resources are readily available. Emergency supplies are checked regularly. Fire evacuation procedures are held six monthly.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is laundered on site. Cleaning and laundry processes are evaluated for effectiveness.

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.

Mt Herbert House has policies and procedures in place that meet the requirements of the restraint minimisation and safe practice standard. There was one resident using a restraint at the time of audit. No residents were using enablers. Restraint processes in place meet the standards.

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 prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent, and manage infections. Specialist infection prevention and control advice is accessed from the Hawke's Bay District Health Board. The programme is reviewed annually.

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, analysed and trended. Results are reported through to the facility owner. 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	0	50	0	0	0	0	0
Criteria	0	101	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	Kaylex Care (Waipukurau) Limited - Mt Herbert House (Mt Herbert) has procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understand 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 including for photographs, outings, invasive procedures, and collection of health information. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the residents' files. Staff demonstrated their understanding by being able to explain situations when this may occur. Training on this was presented to staff by the Health and Disability Advocacy Service on 9 November 2021.

		Staff were observed to gain consent for day-to-day care on an ongoing basis.
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 related to the Advocacy Service were also displayed in the facility. Family/whanau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.
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	When Covid-19 restrictions are not in place, residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Due to Covid-19 restrictions, the facility has restricted visiting hours and entry criteria, though encourage visits from residents' families and friends. When visiting was not possible, 'Zoom', 'Facetime', phone calls and newsletters were used to keep family members in contact. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
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 requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrance. The facility manager (FM) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Education relating to the Code was last provided by the advocate from the Health and Disability Commissioner's office on the 9 November 2021 and included Right 10 - complaints. Review of the complaint register and interview of the FM evidenced no complaints have been received since the previous audit. There have been no complaint investigations undertaken by external agencies since the previous audit. The complaint investigation by the Health and Disability Commissioner referred to in the previous certification audit report has been closed. The request by HealthCERT for comments relate to this previous complaint investigation.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Eight residents and four family/whanau interviewed, report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. The Code is available in te reo Māori, and a Māori cultural handbook is part of the admission pack information.
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/whanau confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussions with families and the general practitioner (GP) or nurse practitioner (NP). All residents have a private room. When Covid-19 restrictions do not limit activities, residents are encouraged to maintain their independence by participating in community activities, attending regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each care plan 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 is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.
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 acknowledges their individual and cultural, values and beliefs.	FA	There are nine residents and 10 staff at Mt Herbert at the time of audit who identify as Māori. Four of the 10 staff who identify as Māori speak fluent te reo. Signage around the facility includes the use of te reo Māori. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. Staff have assisted residents who choose to do so to have their own pepeha written. Māori songs/waiata are included in the singing sessions that are part of the activities programme, as is cooking sessions that enable Māori residents to prepare and partake in 'boil ups' and making Māori bread. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau to Māori residents. A Māori cultural handbook is part of the admission pack information provided for new residents. There is a current Māori health plan developed with input from cultural advisers. Māori residents are supported by several staff who identify as Māori, the Hawke's Bay District Health Boards (HBDHB) Māori liaison nurse at the local health centre, or from the Māori health

		unit at the HBDHB.
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 all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this confirmed that those 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/whanau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A NP also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Mt Herbert encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, mental health services for older people, behavioural therapists, and education of staff. The NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive regular in-service training. When this has been hampered by Covid-19 restrictions, online training has been provided, with follow up questionnaires to assess staffs' knowledge base. The RN's have access to online training through the HBDHB and all caregivers are trained in the fundamentals of palliative care. The clinical nurse manager (CNM) is enabled to work alongside staff and ensure high care standards are maintained. A high percentage of staff have NZQA levels three or four qualifications in care of the older adult.

		Mt Herbert takes a range of residents, including some with complex needs, who are unable to reside in other facilities due to their complexity. All staff have had training from a behavioural therapist to enable them to deal with the often complex behaviours exhibited by these residents. An interview with an allied health provider who works closely with Mt Herbert's staff was complimentary of how accommodating and responsive Mt Herbert was in enabling a resident centred approach to care. Other examples of good practice observed during the audit included a commitment to a reduction in the use of restraint.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whanau members stated they were kept well informed about any changes to their own or 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. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code. Training on this was presented to staff by the Health and Disability Advocacy Service on 9 November 2021. Interpreter services can be accessed via multilingual staff, family members or the HBDHB. Staff reported interpreter services were rarely required due to all present residents being 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	The business plan includes a vision, mission, corporate values, philosophy, goals, objectives and includes a 'strengths, weakness, opportunity and threat' (SWOT analysis.) The business plan is reviewed at least annually. The strategic plan is divided into sections including economic, sociocultural, political/legal, demographic and technological. An organisational chart shows the structure of the organisation and reporting lines. The FM liaises with the general manager (GM) daily and all activities concerning Mt Herbert are discussed. The FM also provides monthly reports to the GM including maintenance, quality, finances, complaints and any feedback. Review of the reports and interview of the FM confirmed this. The facility is managed by an experienced FM/RN who has been in the position since 2012. The FM completed an auditing course in September 2020 and attends clinical forums provided by the local DHB. The management of clinical services is the responsibility of the clinical nurse manager (CNM). The previous CNM left employment in October 2021 when the current CNM started in the position. Prior to this role the current CNM was the senior RN leader at Mt Herbert House. The FM advised the CNM will move into a quality coordinators role when a new experienced CNM starts employment in January 2022. The annual practising certificate for the FM and CNM were current. There was evidence in the managers'

		files of keeping up to date clinically. The FM reported the change of CNM has been advised to HealthCERT. Mt Herbert House has contracts with the local DHB. On the first day of the audit, 37 residents were receiving services. Aged related residential care contract-30 residents (14 hospital and 16 rest home). Long-term chronic -4 hospital under the age of 65 years, respite-1 under a mental health contract. Two residents are under an ACC contract. Although all beds have been approved for use as dual purpose, the FM advised the rest home and hospital residents are mostly accommodated in separate wings.
Standard 1.2.2: Service Management 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.	FA	The FM and CNM work fulltime. When the FM is temporarily absent, the CNM fills the role. When the CNM is away, the FM fills in. The FM and CNM reported this arrangement works well.
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	A quality and risk framework guides the quality programme and includes planning, setting standards, service delivery, monitoring and evaluation and reporting. Quality systems are well embedded at Mt Herbert House. Service delivery is linked to quality and risk throughout a number of documents including health and safety, clinical, incident and accidents and infection control. Resident and staff meetings are held regularly and evidenced reporting of clinical indicators, any trends and discussions around corrective actions. Meeting minutes reviewed included the people responsible for any corrective actions, timeframes for completion and sign off. Any corrective actions not completed are brought forward to the following meeting. The audit programme for 2021 and completed audits were reviewed. Resident and family surveys for 2021 evidenced satisfaction with the service provided. Interviews of residents and families confirmed this. Quality data is entered electronically. Data is collated and analysed to identify any trends. Corrective actions are developed and implemented for deficits identified. Various graphs showing quality data trends are generated annually and each month and are available for staff. Monthly reports are provided to the GM and evidenced inclusion of quality data. The Assessment and Management of the Acutely Unwell Resident Policy has been reviewed and updated/amended to better reflect the process and offers good guidance for clinical staff. All documents

		are controlled and reviewed at least two yearly and are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. New or updated documents are put up on the notice board for staff to read and sign off on. Obsolete documents are archived. Hazards are recorded in the hazard register and newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood what constituted a hazard and the process around reporting. Actual and potential risks are identified and documented in the risk register, including risks associated with human resources management, legislative compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. The maintenance person is the health and safety representative who demonstrated a sound knowledge of health and safety processes. The health and safety representative is enrolled to complete a health and safety course in March 2022 after it was cancelled this year.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Adverse, unplanned or untoward events are documented by staff on incident/accident forms electronically. These are reviewed by the CNM who investigates and implements any corrective actions required and enters all incidents/accidents into a log. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Residents' files evidenced communication with families following adverse events involving the resident, or any change in a resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The FM advised there has been one section 31 notice to HealthCERT since the previous audit relating to a pressure injury that was acquired prior to admission to Mt Herbert.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	FA	Policies and procedures relating to human resources management are in place. Staff files are managed well and included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records, visas and police vetting. The induction programme includes an orientation pack for both nonclinical and clinical staff with competencies. New health care assistants (HCAs) are 'buddied' with a level 4 HCA for up to a month; the length of time depends on past experience in aged care. The orientation is completed within a month of

the requirements of legislation.		employment including competencies with an informal review and annual performance appraisal thereafter. Orientation for staff covers all essential components of the service provided. The staff education programme 2021 is provided for staff using study days, online programmes, at handover for specific training and through attendance at sessions provided by the local DHB. External educators take some sessions and staff have been provided with learning packages with questionnaires. All RNs have received training on 'Something's Not Quite Right' - The Deteriorating Patient, provided by the clinical nurse specialist-gerontology, from the DHB. The FM advised a further session is planned for February 2022 when all HCAs will have attended a session. Attendance records and interviews of RNs and HCAs evidenced a good understanding of the assessment and management of the deteriorating resident. Staff are encouraged to complete a New Zealand Qualification Authority education programme (Careerforce) and currently 11 HCAs have attained level 3, 12 have attained level 4. Three HCAs are currently completing Level 4 and four are enrolled to complete level 3. Three HCAs are new. The assessor is one of the RNs. Individual records of education are held electronically. Competencies were current including for medication management and restraint. Attendance records are maintained. The FM and CNM are interRAI trained and have current competencies. All RNs and the activities staff have current first aid certificates. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.
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 and implemented system for determining staffing levels and skill mixes to provide safe service delivery. Staffing levels are reviewed constantly to meet the changing needs of all residents and skill mix. The FM is on call after hours. Care staff reported staffing levels are good and they have no problems completing the work allocated to them. Residents and families interviewed confirmed this. The FM and CNM are full time and work flexi days including weekends. Observations and review of rosters confirmed good staff cover is provided, with staff replaced in any unplanned absence. The FM reported that should there be a need where a change in residents' health status requires this, part time staff are given the opportunity to cover extra hours. There is no pool of casual staff to call on. There are currently five RNs, none of whom are new graduates. Two RNs have two years and five years

		experience in aged care, respectively. The other three RNs have been employed for six months, three months and three weeks. Experience prior to employment at Mt Herbert included working as community nursing, in a private surgical hospital and in acute setting in the DHB. Another RN starts employment in January 2022. The FM stated the RN team is in a rebuilding phase after several resignations. The less experienced RNs are rostered on the morning shifts so that the FM and CNM are available for advice and support. The two ENs are very experienced in aged care and have been employed for many years. One RN and seven HCAs are rostered on the morning shift, one RN and six HCAs on the afternoon shift and one RN and two HCAs on the night shift. Support staff consist of an administrator/educator, another administrator, diversional therapist, an activities assistant, a maintenance person, a gardener, cleaning/laundry staff, a cook and kitchen hands.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP/NP and allied health service provider notes. 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. Electronic medication records are stored in a secure portal.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents are admitted to Mt Herbert 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/whanau are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical nurse manager (CNM). They are also 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. 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 HBDHB '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. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident 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. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. 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 included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP/NP review was consistently recorded on the electronic medicine chart. There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.

		Standing orders are not used at Mt Herbert.
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 cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian 10 November 2021. Recommendations made at that time have been implemented. An up-to-date food control plan is in place. A verification audit of the food control plan was undertaken 1 November 2021. Two areas requiring corrective action were identified; these related to calibration of the thermometer for temperature monitoring and recording the cooling temperatures of cooked foods. These have been attended to and signed off by the Food Control Plan Auditor. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken training in November 2021 and attained a food safety certificate, with kitchen assistant completing relevant food safety training in 2020. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.
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 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. 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 of Mt Herbert are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, cultural and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation, and observation verified the RNs are familiar with requirement for reassessment of a resident when there is an increasing or changing need levels. This was evidenced on site when a resident was noted to be unwell. A referral to the GP was made and included assessment data; however, accessing a GP in a timely manner is difficult. Ongoing nursing strategies were implemented and a request for a NP to see the resident was initiated. All residents have current interRAI assessments completed by two (includes the FM and CNM) trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Behaviour management plans were sighted in residents with behaviours that are a challenge. Comprehensive planning addressed residents' cultural needs. A resident with a stage four pressure injury had a comprehensive wound care plan in place, with evidence to verify the effectiveness of the strategies in place. Specialists' advice in all areas was sought when needed. Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was 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	FA	Documentation, observations, and interviews verified the care provided to residents at Mt Herbert was consistent with their needs, goals, and the plan of care. The effectiveness of the interventions was sighted in several complex areas being managed at Mt Herbert, specifically in relation to the resident admitted with a stage four pressure injury and its ongoing

order to meet their assessed needs and desired outcomes.		management, and the management of complex behaviours. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP 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 the setting of the service.	FA	The activities programme at Mt Herbert is provided by a diversional therapist and an activities assistant and runs five days a week. 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 resident's activity needs are evaluated regularly and as part of the formal care plan review every six months. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, and interests. Individual, group activities and regular events are offered. Examples included 'sit and be fit', cooking, singing, 'bingo', quiz sessions, cultural sessions, and daily news updates. Church sessions and entertainers visiting have been unable to occur due to Covid-19 restrictions. Drives have carried on; however, residents are only allowed to get out in areas where there are no other members of the public. The activities programme is discussed at the residents' meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme enjoyable, and it meets their needs.
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. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed for infections, pain, and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. 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/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. Mt Herbert was observed to have difficulty accessing the GPs of residents who choose another service provider. The GPs were very busy and often unable to call. If the request becomes urgent, the resident is transferred to HBDHB. If the need for other non-urgent services is indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the NP/GP. The resident and the family 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 hazardous substances, generated during service delivery.	FA	Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register was current. Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.
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 is displayed at the front entrance that expires on the 1 April 2022. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways provide adequate room for residents to pass comfortably in all areas. There is a proactive and reactive maintenance programme. The building, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by a maintenance person who demonstrated good knowledge. The testing and tagging of electrical equipment and calibration of bio-medical equipment were current. Hot water temperatures at resident outlets are maintained within the

		recommended range. There are external areas available that are appropriate to the resident groups and setting. External gardens and a courtyard with seating and shade are available for residents to frequent. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.
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 with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Bathrooms have appropriately secured and approved handrails in the toilet/shower areas and other equipment and accessories are available to promote independence. A separate bathroom for staff and visitors is available.
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	Bedrooms provide single accommodation. Adequate personal space is available to allow residents and staff to safely move around in. Equipment was sighted in the rooms with sufficient space for equipment, staff and the resident. The residents' accommodation is personalised with their own furnishings, photos and other personal possessions. Residents and families are encouraged to make the space their own and stated their rooms are suitable for their needs.
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	The facility has a number of areas for residents to frequent. Good access is provided to the lounges and the dining room areas with residents observed moving freely. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas.

Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policies and procedures are documented and guide services. The facility is cleaned to an adequate standard. There are processes in place for the collection, transportation and delivery of linen and residents' personal clothing. Safe and secure storage areas are available, and staff have appropriate and adequate access, as required. Chemicals were labelled and stored safely within these areas, with a closed system in place. Sluice rooms are available for the disposal of soiled water/waste. Hand washing facilities and gel are available throughout the facility. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and the chemical company representative visits monthly and provides training. All laundry is laundered on site including resident's personal clothing. Staff demonstrated a sound knowledge of processes. Residents and families stated they were satisfied with the cleaning and laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A letter from the New Zealand Fire Service (NZFS) dated 16 June 2003 approving the fire evacuation scheme was sighted. A drill is completed six monthly with the last one completed on the 26 July 2021.The results are emailed to the NZFS. Emergency and security management education is provided at orientation and at the in-service education programme. Documented systems are in place for essential, emergency and security services. Policy and procedures document service provider/contractor identification requirements along with policy/procedures for visitor identification. The Emergency and Business Continuity Plan is comprehensive and has been developed with input from the local DHB. Information in relation to emergency and security situations is readily available/displayed for staff and residents. Emergency equipment was accessible, current and stored appropriately. The service has a new call bell system in place that is used by the residents, families and staff members to summon assistance. All residents have access to a call bell. The maintenance person checks call bells. Residents confirmed they have a call bell and staff respond in a timely manner. There is at least one designated staff member on each shift with appropriate first aid training. Staff records sampled evidenced current training regarding fire, emergency and security education. Information in relation to emergency and security situations is displayed and available for staff and residents with evidence of emergency lighting, torches, gas and BBQ for cooking and extra food supplies. Emergency water is maintained in a 2000 litre water tank. Emergency lights are battery powered. External doors are locked at 9pm during the summer months. There are external sensor lights, and a

		security firm checks security at night.
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 entire facility is heated by electric wall heaters. Procedures are in place to ensure the service is responsive to residents' feedback regarding heating and ventilation in the facility. Residents and families confirmed the facility is maintained at an appropriate temperature. The facility is smoke free with an external covered area for smokers.
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	Mt Herbert provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the FM. The infection control programme and manual are reviewed annually. The CNM is the designated infection control 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 quality/risk/staff meeting. Infection control statistics are entered in the organisation's electronic database. 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. At the time of audit, visiting was restricted due to Covid-19 restrictions. Visiting was by appointment, and all persons entering the building were temperature checked. A Covid-19 pandemic plan outlines actions to take for each traffic light or alert level restriction imposed. 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 related responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the	FA	The infection control coordinator (ICC) has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the HBDHB are available and the IC support group meet with the HBDHB four times a year The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICC confirmed the availability of resources to support the programme and any outbreak of an

organisation.		infection. Supplies were observed to be of a quantity that would meet Mt Herbert's needs in the event of an outbreak.
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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included 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, as was appropriate to the setting. 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	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the IC nurse specialist from HBDHB. Content of the training was documented and evaluated to ensure it was relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. 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 objectives, priorities, and methods that have been specified in the infection control	FA	Surveillance of infections at Mt Herbert is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These includes urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.

programme.		The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. The incidence of infections was noted to be low. A good supply of personal protective equipment was available. Mt Herbert has processes in place to manage the risks imposed by Covid-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. The CNM is the restraint coordinator. The restraint co-ordinator demonstrated a sound knowledge relating to minimising restraint use, current and potential risks of restraint, the approval process, and monitoring and review of the restraint process. Enablers are voluntary and residents reported being able to maintain their independence. Restraint meetings are held separately and as part of the staff/quality meetings. A review of the minutes confirmed this. Required documentation relating to restraint and enabler use is recorded. There was one resident using a restraint and no residents using an enabler at the time of audit. The CNM advised equipment including high/low beds, sensor mats, 'landing mats' and perimeter concave mattresses are used so that restraint is not used where possible.
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 process is being followed and a current consent was in place for the use of restraint. Lap belts are the only approved restraint. The restraint approval group comprises the restraint coordinator/CNM, the resident's family member/EPOA and the resident's GP/NP for final sign off. Members of the group interviewed confirmed they are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint, the one resident's file and interviews, that there were clear lines of accountability, that restraint has been approved, and the overall use of restraint is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision making was on file and was evidenced in the care plan for the person using a restraint.
Standard 2.2.2: Assessment Services shall ensure rigorous	FA	Assessment for the use of restraint was documented and included all requirements of the standard. The CNM interviewed described the documented process. Family members confirmed their involvement. The

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		GP/NP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of the resident who was using a restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The use of restraints is actively minimised, and the CNM/restraint coordinator and other staff described how alternatives to restraint is discussed with staff and family members. When restraint is in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained and reviewed at each restraint approval group meeting. The register was reviewed and contained the resident currently using a restraint and sufficient information to provide an auditable record. Staff training records showed that education and updates about restraint minimisation has occurred this year. New staff are oriented to the organisation's policy and procedures and other related topics, such as positively supporting people with challenging behaviours. Staff understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of the resident's file evidenced the individual use of restraint is reviewed every three months and evaluated during six monthly care plan and interRAI reviews. The resident is also reviewed at the approval group meetings. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure 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	A quality review of restraint is completed annually and includes all the requirements of this Standard. The most recent review occurred in January 2021. Individual use of restraint use is reported monthly via various meetings. Minutes of the restraint quality review confirmed that the review included 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 GP/NP, staff and families. Any changes to policies, guidelines, education, and processes are implemented if indicated.

Specific results for criterion where corrective actions are required

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

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

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

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.

No data to display

End of the report.